| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225298 | A. Building<br>B. Wing | 08/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Northwood Rehabilitation & Healthcare Center | 1010 Varnum Avenue<br>Lowell, MA 01854 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on observations and interview, the facility failed to provide each resident with an over the bed table on 1 out of 3 units. Specifically, the C unit had tray tables for only 19 of the 41 beds available on the floor. Findings include:On 8/12/25 at 7:35 A.M., Certified Nursing Assistant (CNA) #5 said he has worked at the facility for several years and has noticed that in recent months the over the bed tables on the C unit have been taken to other units for use, leaving the residents on the C unit without enough tables. CNA #5 said the residents on the C unit are forced to share tables from room to room, creating a wait time for passing out meals, inability to leave activity materials within reach for residents, and eliminating a place for residents to keep personal items. CNA #5 said he has taken this concern to the Administrator for several months without a response. The surveyor observed all rooms on the C unit and observed that the unit only has 19 tray tables for 41 available beds. On 8/12/25 at 12:15 P.M., the surveyor observed a family member exiting a room to come to the nurse's station to ask for a tray table so she could provide her mother with coffee and a snack. The staff took a table from the hallway that had been used by a resident for an activity task and gave it to the family member to take to her mother's room. On 8/13/25 at 8:32 A.M., the surveyor observed a staff member bringing a meal into a room for a resident's breakfast. The resident did not have a tray table in her room, and the staff member had to bring the meal back to the hallway and find a table to bring into the resident's room. On 8/13/25 at 9:49 A.M., a resident was brought into the hallway from their bedroom to sit for an activity task. There was no table available for the activity and a staff member had to retrieve a table from a different resident's room. On 8/13/25 at 12:30 P.M., the surveyor observed a staff member bringing a meal into a room for a resident's breakfast. The resident did not have a tray table in her room, and the staff member had to bring the meal back to the hallway and find a table to bring into the resident's room. During an interview on 8/13/25 at 9:53 A.M., CNA #1 said not every resident has an over bed table and they often have to bring them back and forth between residents and rooms. During an interview on 8/14/25 at 12:01 P.M., the Administrator said he was aware the C unit did not have enough tables for each resident. The Administrator said he thought his maintenance director had ordered 22 tables, but he was unable to provide an order history for the tables. The Maintenance Director was on vacation and unavailable for interview. |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs) for dependent residents for five Residents (#66, #47, #52, #12 and #79) out of a total sample of 27 residents. Specifically:For Resident #66 the facility failed to provide timely incontinence care.For Residents #47, #52 and #12, the facility failed to provide supervision with meals as indicated in the Resident's plan of care.For Resident #79, the facility failed to ensure facial hair was being shaved.Findings include: 1<br><br>Review of facility policy, titled Activities of Daily Living, dated April 2015 indicated the following:<br><br>-A program of activities of daily living (ADL) is provided to residents to maintain or restore maximum functional independence. The ability for each resident to meet the demands of daily living is assessed by a licensed nurse and/or other members of the interdisciplinary team. A program of assistance and instruction in ADL skills is developed and implemented based on the individual evaluation to encourage the highest level of functioning. This process is reviewed minimally quarterly.<br><br>1. Resident #66 was admitted to the facility in November 2024 with diagnoses that included metabolic encephalopathy, acute kidney failure, dementia and aphasia.<br><br>Review of Resident #66's most recent Minimum Data Set (MDS) Assessment, dated 7/11/25, indicated that the Resident could not participate in the Brief Interview for Mental Status (BIMS) exam and was assessed by staff to be severely impaired with cognitive skills for daily decision making. The MDS further indicated that the Resident was always incontinent of bowel and bladder and is dependent on staff for toileting hygiene and activities of daily living (ADLS).<br><br>On 8/13/25 the surveyor observed Resident #66 continuously from 7:42 A.M. to 1:15 P.M.<br><br>At 7:42 A.M., Certified Nurse's Aide (CNA) #1 brought Resident #66 into the dining room before breakfast was served. Resident #66 was brought to the dining room in a high back wheelchair and remained in the chair for the duration of the observation.<br><br>Beginning at 11:22 A.M., the surveyor observed a fecal and urine like odor in the day room around Resident #66.<br><br>At 11:25 A.M., the surveyor observed Resident #66 attempting to stand up from his/her wheelchair with an uncomfortable look on his/her face.<br><br>At 11:47 A.M., the surveyor observed Resident #66 attempting to stand up from his/her wheelchair again. CNA #1 approached the Resident and said, sit in your chair, where are you going? The CNA then covered the Resident with a blanket on his/her lap but did not attempt to provide any care to the Resident.<br><br>During an interview on 8/13/25 at 12:05 P.M., CNA #1 said that incontinent residents should be checked and changed every two hours. When asked if the CNA could smell any fecal or urine odor in the dining room, she said that she usually wears a mask so hadn't noticed. CNA #1 said that Resident #66 is incontinent of bowel and bladder and the last time that he/she was checked and changed was when he/she was brought into the dining room this morning. CNA #1 said that usually hospice comes<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | in to assist the Resident, but today, hospice has not been in. She said that Resident #66 had not received incontinence care since he/she was initially brought into the dining room.<br><br>Resident #66 is unable to participate in an interview.<br><br>At 1:15 P.M., CNA #1 brought Resident #66 from the dining room to his/her room. The surveyor observed incontinence care provided. The Resident had both feces and urine in his/ her brief. The Resident's skin was intact with mild redness noted around the peri area.<br><br>Review of Resident #66's Bowel and Bladder Assessment, dated 4/7/25 indicated the following:<br><br>-Bowel: incontinent/ complete evaluation in full.<br><br>-Bladder- incontinent/ complete evaluation in full.<br><br>-Factors related to incontinence: impaired mobility, confusion/ dementia.<br><br>-cognitive status: confused always.<br><br>-Resident is a check and change management program- Resident will be checked for incontinence and peri-care provided after each incontinent episode.<br><br>Review of Resident #66's care card (a document that provides information about the level of assist a resident requires) indicated that Resident #66 was incontinent of bowel and bladder and was dependent for toileting hygiene.<br><br>Review of Resident #66's active bowel and bladder care plan, dated 11/22/24, indicated that Resident #66 has an alteration in elimination related to incontinence, bladder incontinence, with interventions that include to Check resident regularly for incontinent episodes.<br><br>Review of Resident #66's most recent Norton Assessment (an assessment completed to determine the risk for skin breakdown), dated 7/8/25, indicated a score of 6 which indicates high risk for skin breakdown. The Norton Assessment indicated, in part, that the Resident had poor physical condition and incontinence of bowel and bladder.<br><br>During an interview on 8/13/25 at 12:17 P.M., Nurse #4 said that Residents who are incontinent of bowel and or bladder should be changed every two hours. She said that not doing so would place the Resident at risk for skin breakdown. She said that skin breakdown can occur within one day. Nurse #4 further said that Resident #66 is on her assignment today and has not been made aware of any refusals of care.<br><br>During an interview on 8/14/25 at 6:55 A.M., Nurse #2 said that she expects CNAs to check change and reposition residents who are incontinent every two hours. Nurse #2 said that not providing this care every two hours places the residents at risk for skin breakdown.<br><br>During an interview on 8/14/25 at 7:01 A.M., CNA #8 and CNA #9 said if a resident is incontinent of bowel and or bladder, they should be checked and changed every two to three hours.<br><br>During an interview on 8/13/25 at 2:02 P.M., the Director of Nurses said that residents who are<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | known to be incontinent of bowel and bladder should be checked every two hours and changed. She said that not performing this task could lead to skin breakdown and said that skin breakdown can happen very quickly.<br><br>2.2a. Resident #47 was admitted to the facility in September 2023 with diagnoses that included protein calorie malnutrition, dysphagia (difficulty swallowing) and weakness.<br><br>Review of Resident #47's most recent Minimum Data Set (MDS) Assessment, dated 6/6/25, indicated a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated the need for supervision or touching assistance with eating meals.<br><br>Review of Resident #47's active (activities of daily living (ADL) care plan, dated as revised 6/18/25, indicated:<br><br>Eating: supervision or touching assistance.<br><br>Review of Resident #47's CNA (Certified Nurse's Assistant) care card (a document that indicates the level of assistance required by a resident) indicated that Resident #47 required set up assistance for meals.<br><br>On 8/12/25 at 8:35 A.M., the surveyor observed a staff member bring the breakfast meal to Resident #47's room, set up the Resident in bed with a tray table and leave the room. The Resident was left in the room alone eating breakfast.<br><br>During a continuous observation on 8/13/25 from 8:32 A.M. to 8:43 A.M., the surveyor observed a staff member bring Resident #47 their breakfast meal, set the Resident up in bed with their meal and leave the room, leaving the Resident alone to eat in his/her room.<br><br>On 8/13/25 at 12:30 P.M., the surveyor observed a staff member bringing the lunch meal into Resident #47's room, setting up the meal, and leaving the room. The Resident was left alone to eat in his/her room.<br><br>On 8/14/25 at 9:04 A.M., Resident #47 was observed in bed, alone, eating breakfast in his/her room.<br><br>During an interview on 8/14/25 at 11:32 A.M., Nurse #7 said that Resident #47 needs cues and reminders while eating because he/she tends to fall asleep during meals. Nurse #7 said that Resident #47 should not be eating alone in his/her room and staff should remain in the room with the Resident. Nurse #7 also said that Resident #47 has a diagnosis of dysphagia so is at an increased risk for choking.<br><br>During an interview on 8/14/25 at 11:35 A.M. CNA #1 said that she was assigned to care for Resident #47 and that he/she does not need assistance with meals.<br><br>During an interview on 8/14/25 at 10:12 A.M., the Director of Nursing said that the requirement of supervision or touching assistance in the care plan indicates that a resident should not be eating alone in their room. She further said that the CNA card should be accurate and up to date. She said it should match the care plan and MDS assessment, which would be the most up to date and accurate indication of the level of assistance required to care for a Resident.<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2b. Resident #52 was admitted to the facility in January 2024 with diagnoses including dementia.<br><br>Review of Resident #52's most recent Minimum Data Set (MDS) dated [DATE], indicated Resident #52 had a Brief Interview for Mental Status (BIMS) score of 1 out of a possible 15, which indicated the Resident has severe cognitive impairment. The MDS also indicated Resident #52 requires supervision for meals.<br><br>On 8/12/25 at 9:10 A.M., Resident #52 was observed lying in bed eating breakfast. There were no staff in his/her room or the hallway to provide supervision or assistance if needed. Resident #52 had spilled approximately 75% of his/her hot chocolate on his/her lap and there was food on his/her chest. When asked, the Resident said he/she spilled his/her drink but could not say more.<br><br>On 8/13/25 at 8:41 A.M., Resident #52 was observed lying in bed eating breakfast. There were no staff in his/her room or the hallway to provide supervision or assistance if needed. Resident #52 had a significant amount of cheerios and milk on his/her chest and was attempting to scoop more cereal from the bowl and was unsuccessful.<br><br>On 8/14/25 at 8:31 A.M., Resident #52 was observed lying in bed eating breakfast. There were no staff in his/her room or the hallway to provide supervision or assistance if needed. Resident #52 had a significant amount of cheerios and milk on his/her chest.<br><br>Review of Resident #52's activity of daily living care plan last revised 3/6/25, indicated the following intervention:<br><br>-Eating: supervision or touching assist.<br><br>Review of Resident #52's care card (a form indicating the level of assistance a resident requires) indicated Resident #52 requires supervision or touching assistance with meals.<br><br>During an interview on 8/15/25 at 8:07 A.M., Certified Nursing Assistant #5 said Resident #52 requires supervision with all meals.<br><br>During an interview on 8/14/25 at 9:07 A.M., Nurse #1 said Resident #52 requires supervision with meals.<br><br>During an interview on 8/14/25 at 11:33 A.M., the Director of Nursing said people who are supervised for meals should have staff repeatedly checking on them throughout the meal. The Director of nursing said that if a care plan also says touching assistance the staff should be with the resident for the entire meal. The Director of Nursing said Resident #52 requires supervision throughout his/her meal.<br><br>2c. Resident #12 was admitted to the facility in August 2023 with diagnoses including dysphagia and Alzheimer's Disease<br><br>Review of Resident #12's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 6 out of a possible 15, which indicated he/she has severe cognitive impairment. The MDS also indicated Resident #12 requires supervision for self-feeding tasks.<br><br>On 8/12/25 at 9:10 A.M., Resident #12 was observed lying in bed eating breakfast. There were no<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | staff in his/her room or the hallway to provide supervision or assistance if needed. Resident #12 had a significant amount of food on his/her chest.<br><br>On 8/13/25 at 8:38 A.M., Resident #12 was observed lying in bed eating breakfast. There were no staff in his/her room or the hallway to provide supervision or assistance if needed. Resident #12 had a significant amount of food on his/her chest.<br><br>On 8/14/25 at 8:39 A.M., Resident #12 was observed lying in bed eating breakfast. There were no staff in his/her room or the hallway to provide supervision or assistance if needed. Resident #12 had a significant amount of food on his/her chest.<br><br>Review of Resident #12's activity of daily living care plan last revised 7/30/25, indicated the following intervention:<br><br>-Eating: supervision or touching assistance.<br><br>Review of Resident #12's care card (a form indicating the level of assistance a resident requires) indicated Resident #12 requires supervision or touching assistance with meals.<br><br>During an interview on 8/15/25 at 8:07 A.M., Certified Nursing Assistant #5 said Resident #12 requires supervision with all meals.<br><br>During an interview on 8/14/25 at 9:07 A.M., Nurse #1 said Resident #12 requires supervision with meals.<br><br>During an interview on 8/14/25 at 11:33 A.M., the Director of Nursing said people who are supervised for meals should have staff repeatedly checking on them throughout the meal. The Director of nursing said that if a care plan also says touching assistance the staff should be with the resident for the entire meal. The Director of Nursing said Resident #12 requires supervision throughout his/her meal.<br><br>3. Resident #79 was admitted to the facility in August 2024 with diagnoses including heart disease type 2 diabetes mellitus.<br><br>Review of Resident #79's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 15 out of 15 indicating intact cognition. Further review of the MDS indicated that that the Resident requires partial/moderate assistance for personal hygiene (The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands).<br><br>On 8/12/25 at 9:31 A.M., the surveyor observed Resident #79 sitting up in his/her chair, he/she had white facial hair on his/her chin, upper lip and cheeks. The Resident told the surveyor that he/she wants his/her face shaved and he/she cannot do it because his/her hands do not work well. The Resident then said he/she wishes staff would shave his/her face more often, but he/she feels like there are not enough staff on the unit to do it.<br><br>On 8/13/25 at 12:10 P.M., Resident #79 was eating his/her lunch in the dining room, he/she had white facial hair on his/her chin, upper lip and cheeks.<br><br>On 8/14/25 at 1:28 P.M., Resident #79 was sitting in his/her wheelchair on the first floor, he/she had (continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | white facial hair on his/her chin, upper lip and cheeks. Resident #79 told the surveyor that he/she really wants his/her face shaved weekly and it has not happened recently. Resident #79 then said he/she wants the Certified Nursing Assistants (CNA) to shave his/her face, but they are always too busy and do not have time to do it.<br><br>Review of Resident #79's Kardex (a facility care card that indicates the level of a care a resident needs) indicated that the Resident requires partial/moderate assistance for personal hygiene (grooming).<br><br>Review of Resident #79's ADL Deficit care plan dated 9/13/24, indicated the following intervention: Personal Hygiene – Partial assist.<br><br>Review of Resident #79's Personal Hygiene CNA documentation for July 2025 indicated that the Resident required either substantial/maximum assistance or dependence on staff for 27 out of the 31 days.<br><br>Review of Resident #79's Personal Hygiene CNA documentation on 8/14/25 for August 2025 indicated that the Resident required either substantial/maximum assistance or dependence on staff for 10 of the 14 elapsed days.<br><br>During an interview on 8/14/25 at 1:31 P.M., CNA #10 said Resident #79 needs help from staff for ADLs and hygiene because his/her hands do not work so well. CNA #10 said he/she needs set-up assistance for using his/her electric razor to shave his/her face. CNA #10 then said if staff notices facial hair on a resident, they should ask the resident if they would like it removed.<br><br>During an interview on 8/14/25 at 1:40 P.M., Nurse #6 said if a CNA observed facial hair on a resident they should ask if he/she wants it removed.<br><br>During an interview on 8/14/25 at 1:54 P.M., the Director of Nursing (DON) said if staff notice facial hair on a resident they need to offer to shave it. The DON then said partial/moderate assistance means a resident needs help with that ADL task. The DON said Resident #79 should have been ask if he/she wants his/her facial hair shaved. |

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|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the Registered Dietitian and Physician of a significant change in nutritional status for one Resident (#12) out of a total sample of 27 residents. Findings include:Review of the facility policy titled, Weights, undated, indicated the following:-If a significant weight loss gain is identified (> 5% in 30 days or > 10% in six months), the IDT (interdisciplinary team), dietitian, physician and family are notified.-All residents with a significant weight loss are reviewed by the interdisciplinary team and the resident/responsible party and interventions implemented as appropriate and are monitored weekly. Resident #12 was admitted to the facility in August 2023 with diagnoses including dysphagia, diabetes, and Alzheimer's Disease. Review of Resident #12's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 6 out of a possible 15, which indicated he/she has severe cognitive impairment. The MDS also indicated Resident #12 requires supervision for self-feeding tasks and is dependent on staff for all other self-care and mobility tasks. Review of Resident #12's weights indicated that on 7/14/25, the Resident weighed 257.2 lbs. (pounds) and on 8/6/25, the Resident weighed 240.4 lbs. which is a -6.53% significant weight loss. During an interview on 8/14/25 at 8:38 A.M., Resident #12 said he/she was unaware he/she had lost any weight, and no one had come to speak with him/her about it. Review of Resident #12's medical record failed to indicate the following:-The physician or Dietitian were notified of the weight loss.-The Dietitian reviewed Resident #12's weight loss and addressed the loss.-Resident #52 was followed by the risk management team. During an interview on 8/14/25 at 9:07 A.M., Nurse #1 said all residents are weighed according to the physician orders and if a significant change in weight occurs, the nursing staff should obtain a reweight within 24-48 hours to validate the significant change. Nurse #1 said if the significant weight change is validated, the dietitian, physician, and interdisciplinary team should be notified and an intervention put in place immediately to prevent further weight loss. Nurse #1 said she works full time on Resident #12's unit and was unaware the Resident had lost any weight and therefore did not notify the physician or dietitian of any weight loss. During an interview on 8/14/25 at 10:23 A.M., the Registered Dietitian (RD) said she works at the facility two days a week and reviews a weight report to follow all residents' weights and to identify any weight changes that occurred. The RD said the facility also has weekly risk management meetings and she is also notified of a resident's significant weight change during these meetings. The RD said if a resident were to have a significant weight loss, which would be over 5% in one month, the nursing staff should complete a reweight of the resident within 24-48 hours to validate the loss. The RD said if the weight loss is validated, she should be notified by the nursing staff, and a nutritional intervention should be put in place immediately. The RD said she often finds weight loss herself by looking at the report and the nursing staff does not always notify her of significant weight changes in the facility. When reviewing Resident #12's medical record with the surveyor, the RD confirmed the Resident's significant weight loss and said she was never notified of the loss, that the Resident was never discussed in risk meeting, that a reweight was never obtained as it should have been and that an intervention was never put in place as it should have been. The RD said she would have to assess Resident #12 because she felt the Resident would benefit from increased supplementation. During an interview on 8/14/25 at 11:03 A.M., Physician #1 said he was not aware of Resident #12's weight loss and had not been notified by the facility. During an interview on 8/14/25 at 11:33 A.M., the Director of Nursing said all residents are weighed monthly unless otherwise ordered and the facility monitors these weights to check for any significant weight changes. The Director of Nursing said if a significant weight change occurs, the facility must notify the physician and dietitian and put a new nutritional intervention in place immediately. The Director of Nursing said she was unaware the physician and dietitian were not notified of Resident #12's weight loss. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 225298 | A. Building<br>B. Wing | 08/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Northwood Rehabilitation & Healthcare Center | 1010 Varnum Avenue<br>Lowell, MA 01854 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on observations, record review, and interviews, the facility failed to ensure one Resident (#66) was free from neglect out of a total sample of 27 residents. Specifically, for Resident #66, the facility neglected to provide the necessary care for incontinence management. Findings include: Resident #66 was admitted to the facility in November 2024 with diagnoses that included metabolic encephalopathy, acute kidney failure, dementia and aphasia. Review of Resident #66's most recent Minimum Data Set (MDS) Assessment, dated 7/11/25, indicated that the Resident could not participate in the Brief Interview for Mental Status (BIMS) exam and was assessed by staff to be severely impaired with cognitive skills for daily decision making. The MDS further indicated that Resident #66 was always incontinent of bowel and bladder and is dependent on staff for toileting hygiene and activities of daily living (ADLS). On 8/13/25 the surveyor observed Resident #66 continuously from 7:42 A.M. to 1:15 P.M. At 7:42 A.M., Certified Nurse's Aide (CNA) #1 brought Resident #66 into the dining room before breakfast was served. Resident #66 was brought to the dining room in a high back wheelchair and placed at a dining table in the corner of the room. Resident #66 sat in this position in the dining room for the duration of the observation. Beginning at 11:22 A.M., the surveyor observed a fecal and urine like odor in the day room in the area Resident #66 was sitting. At 11:25 A.M., the surveyor observed Resident #66 attempting to stand up from his/her wheelchair with a grimace on his/her face. At 11:47 A.M., the surveyor observed Resident #66 attempting to stand up from his/her wheelchair again. CNA #1 approached the Resident and said, sit in your chair, where are you going? The CNA then covered the Resident with a blanket on his/her lap and did not attempt to provide any further care for the Resident. During an interview on 8/13/25 at 12:05 P.M., CNA #1 said incontinent residents should be checked and changed every two hours on a perfect day, meaning a day with enough staffing. CNA #1 said that the unit was staffed with four CNA's today, which was ideal staffing for all care to be provided to the residents. When asked if the CNA could smell any stool or urine in the dining room, she said that she usually wears a mask so hadn't noticed, and said there was one resident who was removed from the dining room earlier in the day because they had moved their bowels but didn't notice an odor at this time. CNA #1 said she was the primary CNA for Resident #66 today and said the Resident is incontinent of both bowel and bladder. CNA #1 said she provided incontinence care for Resident #66 this morning prior to bringing the Resident to the dining room before breakfast. CNA #1 said Resident #66 also receives care from hospice and that a hospice aide typically comes in to assist the Resident, but today, hospice has not been in, and Resident #66 has not received incontinence care since he/she was initially brought into the dining room. After discussing Resident #66's incontinence needs, CNA #1 did not attempt to provide care to the Resident. At 12:12 P.M., lunch was delivered to the unit and Resident #66 remained in the dining room. The odor of feces and urine was still present in the room in the area of the Resident. At 12:57 P.M., staff were observed assisting Resident #66 with the lunch meal. Resident #66 has continued to remain in the dining room and has not been provided with any incontinence care. The surveyor continued to observe fecal and urine like odors in the dining room during the lunch meal. During an interview on 8/13/25 at 12:59 P.M., Nurse #4 said that she is the nurse assigned to care for Resident #66 today and has not been made aware of any behaviors of refusal of care. The surveyor asked if she knew whether Resident #66 had been provided with incontinence care, and she said she would check with CNA #1. Nurse #4 immediately approached CNA #1 and asked if the Resident had received care. Nurse #4 said that the Resident had not received care and as soon as the Resident is done eating, CNA #1 would change the Resident. At 1:15 P.M., CNA #1 brought Resident #66 from the dining room to his/her bedroom. CNA #1 provided incontinence care, and the surveyor observed the care provided. The surveyor observed Resident #66 had both stool and urine in his/her brief and he/she had mild redness noted on the skin of the peri area (the region of skin in the genitals and anus).<br>(continued on next page) |

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| | 225298 | A. Building<br>B. Wing | 08/15/2025 |

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| Northwood Rehabilitation & Healthcare Center | 1010 Varnum Avenue<br>Lowell, MA 01854 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #66 was unable to participate in an interview. Review of Resident #66's Bowel and Bladder Assessment, dated 4/7/25 indicated the following:-Bowel: incontinent/complete evaluation in full.-Bladder- incontinent/complete evaluation in full.-Factors related to incontinence: impaired mobility, confusion/ dementia.-Cognitive status: confused always.-Resident is a check and change management program- Resident will be checked for incontinence and peri-care provided after each incontinent episode. Review of Resident #66's care card (a document that provides information about the level of assistance a resident requires) indicated Resident #66 had incontinence of bowel and bladder and was dependent on staff for toileting hygiene. Review of Resident #66's active bowel and bladder care plan, dated 11/22/24, indicated that Resident #66 has an alteration in elimination related to incontinence, bladder incontinence, with interventions that include to Check resident regularly for incontinent episodes. Review of Resident #66's Mini Nutritional Assessment, date 11/11/24, assessed indicated that the Resident is malnourished. During an interview on 8/13/25 at 2:02 P.M., the Director of Nurses said that residents who are known to be incontinent of bowel and bladder should be checked every two hours and changed as needed. She said that not performing this task could lead to skin breakdown and said that skin breakdown can happen very quickly. She said that malnourishment in addition to incontinence increases the risk for skin breakdown. The Director of Nurses said that not providing incontinence care to an incontinent resident is both a dignity concern as well as a potential for neglect. During an interview on 8/14/25 at 6:55 A.M., Nurse #2 said that she expects CNAs to check change and reposition residents who are incontinent every two hours. Nurse #2 said that not providing this care every two hours places the residents at risk for skin breakdown. Nurse #2 said that not providing incontinence care to a resident who is known to be incontinence for five hours would be neglect. During an interview on 8/14/25 at 7:01 A.M., CNA #8 and CNA #9 said that neglect is a type of abuse that they have been educated about at the facility. They said that not checking and changing an incontinent resident every two to three hours is neglect. During an interview on 8/14/25 at 12:36 P.M., the Clinical Nurse Specialist said that not providing incontinence care to a resident with known incontinence could be considered neglect. During an interview on 8/15/25 at 9:02 A.M., the Administrator said, there is no excuse for what happened to this resident. He said that not providing incontinence care has the potential to be neglect. |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one Resident (#52) was assessed for and free from restraints, out of a total sample of 27 residents. Findings include:Review of the facility policy titled, Restraint Management, dated August 2018, indicated the following: -It is the policy of the facility to utilize restraints only when clinically justifiable to treat the resident's medical condition while maintaining the resident's highest practicable level of physical and psychological wellbeing. Restraints will be utilized only after alternatives to restraints and/or least restrictive restraints have been attempted. The need for a restraint will be evaluated by the interdisciplinary team (IDT) and this recommendation will be reviewed with the residents and/or responsible party. The interdisciplinary team will evaluate the resident on admission, annually, quarterly and initiation of restraint with significant change of condition to determine the need for continued use of the restraint and to evaluate for opportunities to reduce or eliminate the restraint.-Physical restraints is any manual, mechanical or physical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Resident #52 was admitted to the facility in January 2024 with diagnoses including dementia and repeated falls. Review of Resident #52's most recent Minimum Data Set (MDS) dated [DATE], indicated Resident #52 had a Brief Interview for Mental Status (BIMS) score of 1 out of a possible 15, which indicated the Resident has severe cognitive impairment. The MDS also indicated Resident #52 has an impairment in range of motion in the left hand and requires supervision for eating. On 8/12/25 at 9:10 A.M., Resident #52 was observed lying in bed on a scoop mattress (a mattress with raised edges) with the bed at the lowest position. On 8/13/25 at 6:58 A.M. Resident #52 was observed lying in bed on a scoop mattress with the bed at the lowest position. The Resident was attempting to move both legs over the edge of the bed to climb out of bed. On 8/13/25 at 7:41 A.M., and 8:42 A.M., Resident #52 was observed lying in bed on the scoop mattress. A pillow had been placed under the sheet next to the Resident's right leg, preventing the Resident from moving his/her leg over the side of the bed. Review of the restraint assessment, dated 7/7/25, failed to indicate the facility assessed Resident #52's use of a low bed and a scoop mattress as potential restraints. Review of Resident #52's fall care plan, last revised 3/6/25, indicated the following intervention:-Provide environmental adaptations:(Specify) Low/platform bed. During an interview on 8/13/25 at 9:33 A.M., Certified Nursing Assistant (CNA) #5 said Resident #52 constantly attempts to climb out of bed and is able to get out of bed on his/her own. CNA #5 and the surveyor observed Resident #52 lying in bed, and CNA #5 said he had placed the pillow under Resident #52's sheet to prevent the Resident from being able to move his/her legs to the side of the bed and prevent him/her from getting up on his/her own. CNA #5 said the staff put the pillow like this every day or else the Resident would attempt to get up and potentially fall. During an interview on 8/13/25 at 9:46 A.M., Nurse #1 said the facility completes restraint assessments for every resident quarterly and a low bed and scoop mattress should be assessed as potential restraints. Nurse #1 said Resident #52 attempts to climb out of bed on his/her own and a scoop mattress was provided to the Resident as a way to slow his/her movement when attempting to get out of bed. Nurse #1 said a pillow under the sheet would limit a resident's movement intentionally and would be considered a restraint. During an interview on 8/13/25 at 9:53 A.M., the Assistant Director of Nursing (ADON) said restraint assessments are completed quarterly for every resident and that Resident #52 has a low bed and a scoop mattress and these would be considered two interventions that would need to be assessed as potential restraints. The ADON said a pillow under a sheet would be a restraint as it limits the movement of a resident intentionally. During an interview on 8/13/25 at 10:25 A.M., the Director of Nursing (DON) said residents have restraint assessments completed quarterly, and the assessments<br>(continued on next page) |

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| | 225298 | A. Building<br>B. Wing | 08/15/2025 |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | are to include any device or intervention that may be considered a restraint. The DON said Resident #52 has both a low bed and a scoop mattress and these are two interventions that are potential restraints and should be included in the restraint assessment. The DON said pillows are not to be put under sheets on the side of the mattress because this would be used to limit a resident's movement and would be a restraint. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>Based on interview and record review, the facility failed to implement policies and procedures for neglect by a staff member for one Resident (#66), out of 27 residents. Specifically, the facility failed to implement written policies and procedures related to the timely reporting of neglect and removal of the alleged perpetrator from the unit.Findings include:Review of the facility policy titled Abuse, Neglect and Exploitation, dated as implemented February 2023, indicated the following:-Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.-Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be an indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.-VI. Protection of the Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:-A. Responding immediately to protect the alleged victim and integrity of the investigation.-D. Room or staffing changes, if necessary, to protect resident(s) from the alleged perpetrator.-VII. Reporting/Response: The facility will have written procedures that include:-1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Resident #66 was admitted to the facility in November 2024 with diagnoses that included metabolic encephalopathy, acute kidney failure, dementia, and aphasia. Review of Resident #66's most recent Minimum Data Set (MDS) Assessment, dated 7/11/25, indicated that the Resident could not participate in the Brief Interview for Mental Status (BIMS) exam and was assessed by staff to be severely impaired with cognitive skills for daily decision making. The MDS further indicated that Resident #66 was always incontinent of bowel and bladder and is dependent on staff for toileting hygiene and activities of daily living (ADLs). On 8/13/25 the surveyor observed Resident #66 continuously from 7:42 A.M. to 1:15 P.M. During this period of 5 hours and 33 minutes, the facility staff failed to provide necessary incontinence care to the Resident, until the surveyor questioned whether the Resident had received care. When the Resident did receive care, he/she had been incontinent of bowel and bladder. During an interview on 8/13/25 at 12:05 P.M., Certified Nurse's Aide (CNA #1) said that she was assigned to care for Resident #66 on this day (on the C wing unit), and had not provided incontinence care to the Resident since bringing him/her into the dining room at 7:42 A.M. During an interview on 8/13/25 at 2:02 P.M., the Director of Nurses said that residents who are known to be incontinent of bowel and bladder should be checked every two hours and changed as needed. The Director of Nurses said that not providing incontinence care to an incontinent resident is both a dignity concern as well as a potential for neglect. Review of the State Agency Health Care Facility Reporting System (HCFRS) on 8/14/25 at 7:42 A.M., failed to indicate a report of abuse/ suspected abuse/neglect for Resident #66 was made by the facility. Review of the facility schedule for 8/14/25 indicated that CNA #1 was assigned to the C wing unit for the 7:00 A.M. to 3:00 P.M. shift and the surveyor observed CNA #1 working on the unit, providing care to residents, after the allegation had been brought to the attention of administration and during the facility's ongoing investigation. During an interview on 8/14/25 at 10:06 A.M., the Director of Nurses said that an investigation was started into the allegation of neglect that was brought to her attention yesterday, and that she started a grievance yesterday. She said that not providing necessary care to a resident is neglect. The Director of Nurses said that she did not report the allegation to the state agency, but she should have. She said it should have been reported to the state agency within two hours and then investigated to determine the outcome. She said that when<br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | there is an accused they should be removed from the schedule until the investigation is complete, and a conclusion is reached. The Director of Nurses further said that the accused CNA was educated and brought back onto the schedule. She said that the investigation is not completed at this time and is ongoing. During an interview on 8/14/25 at 12:36 P.M., the Clinical Nurse Specialist said that not providing incontinence care to a resident with known incontinence could be neglect, and that any allegation of abuse or neglect should be reported immediately within two hours to the state agency and a full investigation should be completed. During an interview on 8/15/25 at 9:02 A.M., the Administrator said that the allegation should have been reported yesterday when it was brought to the facility's attention. He was not sure if the investigation was complete or not at this time but said that if there was an accused staff member they should be removed from the schedule until the conclusion of the investigation |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to develop and implement person centered care plans for two Residents (#52 and #45), out of a total sample of 27 residents. Specifically, the facility failed:1. For Resident #52, a. to develop a care plan for the use of a scoop mattress,b. to implement a personalized care plan for the use of two staff during activities of daily living, andc. to implement a personalized care plan for the use of a pressure relieving device; and2. For Resident #45, to develop and implement an individualized behavioral care plan. Findings include:<br><br>1. Resident #52 was admitted to the facility in January 2024 with diagnoses including dementia and repeated falls.<br><br>Review of Resident #52's Minimum Data Set (MDS) assessment, dated 7/11/25, indicated Resident #52 had a Brief Interview for Mental Status (BIMS) score of 1 out of a possible 15, which indicated the Resident has severe cognitive impairment. The MDS also indicated Resident #52 requires substantial assistance from staff for activities of daily living.<br><br>a. On 8/12/25 at 9:10 A.M., on 8/13/25 at 6:58 A.M. and 8:34 A.M., and on 8/14/25 at 8:31 A.M., the surveyor observed Resident #52 lying in bed on a scoop mattress (a mattress with raised edges). Resident #52 was unable to answer any questions about his/her mattress.<br><br>Review of Resident #52's medical record indicated the Resident had sustained four falls within the last year.<br><br>Review of Resident #52's fall prevention care plan failed to indicate a scoop mattress was included as a personalized intervention.<br><br>During an interview on 8/13/25 at 9:53 A.M., the Assistant Director of Nursing (ADON) said Resident #52 was provided with a scoop mattress after a fall and this should have been added to the care plan for staff to be aware of its use.<br><br>During an interview on 8/13/25 at 10:25 A.M., the Director of Nursing (DON) said Resident #52 has sustained several falls and had been provided with a scoop mattress as a fall intervention. The DON said all fall interventions should be included when developing the fall care plan.<br><br>b. On 8/12/25 at approximately 10:00 A.M. and on 8/13/25 at 9:45 A.M., Resident was provided morning care by Certified Nursing Assistant (CNA) #5.<br><br>Review of Resident #52's behavioral care plan, last revised 3/6/25, indicated the following intervention:<br><br>-Two staff at all times with ADL (activities of daily living) care. Approach from ride side due to visual deficit.<br><br>Review of Resident #52's care card (a form indicating the level of assistance a resident requires) indicated the following:<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Resident is a two person assist for all ADLs (activities of daily living) due to accusatory (behavior).<br><br>During an interview on 8/13/25 at 9:46 A.M., Nurse #1 said Resident #52 can become agitated with care and can refuse and requires two staff to assist with all personal care.<br><br>During an interview on 8/15/25 at 8:07 A.M., CNA #5 said that Resident #52 requires two staff members for all care.<br><br>During an interview on 8/13/25 at 9:43 A.M., the ADON said Resident #52 often refuses care, swears at staff and has the potential to hit staff so should have two staff members present when providing personal care.<br><br>During an interview on 8/13/25 at 10:25 A.M., the DON said Resident #52 is care planned to have two staff present when care is being provided due to his/her behaviors and the potential of acting out towards staff.<br><br>c. On 8/12/25 at 9:10 A.M., the surveyor observed Resident #52 lying in bed with both of his/her feet laying directly on the bed. There were no pillows by his/her feet on the bed or next to the bed, and there were no heel protective booties observed in the room.<br><br>On 8/13/25 at 7:28 A.M., and 8:41 A.M., the surveyor observed Resident #52 lying in bed with both of his/her feet laying directly on the bed. There were no pillows by his/her feet on the bed or next to the bed, and there were no heel protective booties observed in the room.<br><br>On 8/14/25 at 6:25 A.M., the surveyor observed Resident #52 lying in bed with both of his/her feet laying directly on the bed. There were no pillows by his/her feet on the bed or next to the bed, and there were no heel protective booties observed in the room.<br><br>Review of Resident #52's physician orders indicated the following:<br><br>-Offload heels every shift as tolerated, initiated on 7/18/25<br><br>-Left heel bootie apply at hs (night) and remove AM (in morning) check q (every) shift, initiated on 12/20/24.<br><br>Review of Resident #52's skin integrity care plan last revised 3/6/25, indicated the following intervention:<br><br>-Offload heels while in bed.<br><br>Review of Resident #52's most recent Norton Assessment, dated 7/8/25, indicated the Resident scored a 7 and was at a high risk for pressure ulcer development.<br><br>During an interview on 8/14/25 at 6:35 A.M., Nurse #2 said she did not place the heel protector booties on the Resident during this overnight shift while the Resident was in bed.<br><br>During an interview on 8/13/25 at 9:07 A.M., Nurse #1 said Resident #52 should be offloading his/her heels while in bed.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 8/14/25 at 11:33 A.M., the DON said all plans of care should be implemented as written. The DON said Resident #52 had a previous pressure ulcer on his/her left heel and is at a high risk of the pressure ulcer redeveloping. The DON said the staff should be implementing the Resident's skin care plan and he/she should be wearing a protective heel bootie while in bed and offloading his/her heels.<br><br>2. Resident #45 was admitted to the facility in December 2024 with diagnoses including bipolar disorder and paraplegia.<br><br>Review of the MDS assessment, dated 3/14/25, indicated Resident #45 is cognitively intact evidenced by a score of 15 out of 15 on the BIMS exam. The MDS also indicated Resident #45 had verbal and physical behaviors and behaviors of rejecting care.<br><br>Review of the progress notes indicated Resident #45 had multiple instances of behaviors:<br><br>-12/30/24: This writer has attempted to build rapport with Resident #45 due to difficulty dealing with this resident.Will continue to establish supportive therapeutic relationship.<br><br>-1/4/25: Resident #45 was asked to use his/her cellphone appropriately and not take pictures of other patients or activate alarm noises. This writer discussed helping us to help him/her. Resident #45 stated I understand.<br><br>-1/8/25: .Discussed rough start during his/her stay at [facility] and wishing to turn it around and be more positive an cooperative. [sic]<br><br>-3/11/25: Discussion with Resident #45 about sharing his/her food with other residents. Resident #45 is attempting a nice gesture yet this writer explained that other patients may be on specific diet.<br><br>-4/17/25: Multiple conversations with Resident #45 about treating all with respect. Resident #45 has been disrespectful with multiple patients and staff.<br><br>-4/21/25: Redirected Resident #45 from angry outbursts due to flooded toilet by my next-door neighbors fault. Resident #45's perception was that my anger and yelling would be helpful<br><br>-4/24/25: Multidisciplinary team meeting/intervention with Resident #45 to address how to best assist him/her medically, emotionally and spiritually. Resident #45 has been disrespectful and angry towards staff multiple times each day for a couple weeks. Resident #45 was allowed to share his/her emotional and physical needs and did so appropriately. Staff was attentive and supportive.Resident #45 understands that his/her negative and disruptive outbursts are not in the best interest of all concerned.<br><br>-5/16/25: Late Entry for 5-15-25: Resident giving food again to another resident after being told multiple times to not give him/her food all the time due to [NAME] (sic) weight gain. Redirected without effect continued to give other resident more pizza. S.W. (Social Worker) has been notified of what has been going on. [sic]<br><br>-5/18/25: PT (patient) continue (sic) with increased behaviors, provides another resident in the unit with sugary drinks and snacks despite multiple education from staff.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -5/19/25: SW and SUDs (Substance Use Disorder) Counselor met with Resident #45 about giving food to another resident. He/she states he/she will stop.<br><br>-5/22/25: Continued dialogue with Resident #45 about doing the right thing and treating all with respect. Continuous discussions with Resident #45 about not feeding [another resident] snacks.Resident #45 continues to forget discussion about treating all with respect.<br><br>-5/25/25: 15 minute checks started. (The documentation failed to indicate the reason Resident #45 was placed on 15 minute checks.)<br><br>-5/29/25: PT with increased disruptive behavior in the unit, verbally and socially inappropriate towards staff. PT continues to use abusive and demeaning language towards staff despite education. PT continues to provide another patient in the unit with sugary snacks and orders fast food MacDonalds to that patient. PT is always approached by two staff due to his/her increased verbal confrontation with staff, education and safety reinforced. PT reports I can do whatever I want, I don't need you people here. Continues on 15 minute checks. No unsafe behavior observed.<br><br>-5/30/25: Resident #45 understands why he/she should not feed other residents ice-cream. Resident #45 states he/she will try to be better. Multiple conversations with Resident #45 about appropriate behaviors with all he/she comes into contact with. Resident #45 states he/she understands yet is incapable on following thru on healthy choices and appropriate/good actions.<br><br>-6/1/25: Patient remains on 15 minute checks. Patient was observed using inappropriate language [with] kitchen staff and the aides. Redirection was attempted with minimal effect.<br><br>-6/2/25: Resident #45 was accused by other female residents of inappropriate vernacular Resident states he/she will try to be better. Multiple conversations with Resident #45 about appropriate behaviors with all he/she comes into contact with.<br><br>-6/5/25: Physiatry Note: Subjective: Nursing reports patient is frequently getting upset regarding the smoking and requesting for more cigarettes and also is offering outside food to other residents. He/she is alert and oriented x3, but impulsive and gets agitated with everyone.<br><br>-6/7/25: At 9am Resident #45 was out in front of room [ROOM NUMBER] and refused to leave, stating I can go wherever I want. [Other Resident] stated I don't want you near my room. Patient removed from entrance 15 minute checks in place.<br><br>-6/9/25: Discussed doing the next right thing with Resident #45. Resident #45's perception is that I am right, and everyone else is wrong. This writer will continue with therapeutic dialogue with Resident #45 in attempts to redirect him/her from alienating other residents and staff.<br><br>-6/10/25: Resident #45 out to ER yesterday [on a section-12] after hitting a peer.<br><br>-6/10/25: Discussed last night's interaction with another resident. Resident #45's perception is that I have zero fault! and I am right. This writer will continue therapeutic approach with Resident #45 yet it has been difficult to achieve positive results or redirection due to Resident #45's continued perceptions.<br><br>-6/10/25: Administrator served Resident #45 a 30-day notice of intent to discharge due to incident<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | last night in the presence of SW (social worker). Resident #45 was highly agitated, stating it wasn't true and everybody was lying.<br><br>-6/13/25: Behavioral Health Services Note: Patient seen today for routine assessment and medication review. Mood is unstable with no acute distress. Nursing reports new concerns regarding pt irritability, impulsivity, aggression but his/her sleep is good. Pt reported on being aggressive toward another resident but denies and becomes agitated. Continue with supportive care. Start Depakote 250 mg by mouth once a day and patient continues to benefit from psychiatric medications. Monitor mood, document behaviors and contact [behavioral health services] if needed. Follow up: 1-4 weeks.<br><br>-6/24/25: Refuses to leave door open to his room, refuses to have light on when roommate being attended by nurse. Yells and curses at staff. When door is opened, he/she gets oob (out of bed) and shuts door. Verbal redirection with no effect at all.<br><br>-6/26/25: This writer has had multiple daily conversations with Resident #45 about doing the right thing and treating all with respect. Resident's intentions in conversation are good, yet his/her follow thru with staff and other residents continues to be demanding, righteous and confrontational.Resident #45 seems incapable to realize that his/her actions are not positive or appropriate. [sic]<br><br>-6/27/25: Verbally abusive to a staff member times 3. Verbal redirection without effect.<br><br>-6/27/25: Resident #45 went outside quickly got in van and would not get out even after driver told him/her that he was not able to take him/her. Driver had to take d/t (due to) he/she would not get out of the van. [sic]<br><br>-6/30/25: Nurse Practitioner Note: PT was evaluated by psych on 6/13 due to altercation with another resident. Patient has had increased irritability as well.<br><br>-7/1/25: Late note for 6/28/25: Resident was requesting for medication that was not on his/her medication list, when writer asked what was going on with him/her if he/she was having any discomfort, he/she got very upset and could not gave (sic) the nurse a chance to administer other resident medications. Redirected with negative effects.<br><br>-7/10/25: Continues to give another resident food that he/she should not have. Resident #45 has been told this so many times but continues to give him/her food.<br><br>-7/16/25: When Resident #45 was spoken to about feeding another resident he/she had very vulgar language i.e. go F yourself. I will effing do what I want. Verbally redirected without effect.<br><br>-7/17/28: It has been reported by CNA and other residents that Resident #45 was non-compliant during cigarette breaks, grabbing and pocketing others' cigarettes. Resident #45 denies incident. He/she has been asked to check belongings but refused. Nursing will continue offering education as needed.<br><br>-7/20/25: At approximately 11:30 AM, CNA called me to [Resident #45's room]. Upon arrival, I found Resident #45 cutting another resident's hair with scissors. On the table were a manual and electric shaver that belonged to his/her roommate. When asked to stop, Resident #45 continued cutting. The CNA and I relocated to other resident back to his/her room. We have asked Resident #45 to return the scissors for safety reasons but he/she refused. The lead CNA attempted to redirect him/her without<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | success. NP (Nurse Practitioner) on call has been notified, ordering a Section 12. Resident #45 was transferred to [the hospital] via stretcher, 2 cops were present. DON (Director of Nursing) and Administrator made aware.<br><br>-7/22/25: Nurse Practitioner Note: Over the weekend patient was seen by staff cutting another resident's hair. When asked to give the staff his/her scissors, patent refused and became agitated. Patient was sent out for further psych evaluation. Patient was cleared by psych to return back to [facility] the same day. On today's exam, patient agitated that he/she had to give his/her scissors to staff. Discussed importance of not cutting another patient's hair due to safety concerns.<br><br>-7/24/25: PT noted to be intrusive into pt's rooms today. When asked to leave stated I can be wherever I want! Swearing at nursing staff.<br><br>-7/31/25: Again after multiple times not to give extra food to another resident he/she gave him/her more ice cream and cookies. Verbal redirection without effect.<br><br>-8/12/25: Using abusive words on staff, calling them liars. Distracting other residents from getting care stating, don't believe what they are saying to you.<br><br>Review of Resident #45's behavior care plan on 8/13/25 indicated:<br><br>Focus: Behavior Problem related to diagnosis of Bipolar Disorder. He/she can be verbally abusive: curses and screams at others. He/she is resistive to care and redirection and my wander, initiated 1/2/25, revised 7/16/25. Interventions: Explain care in advance, in terms resident understands. If reasonable, discuss behavior, explain/reinforce why behavior is unacceptable. Intervene as needed to promote the rights & safety of others; approach in calm manner, divert attention, remove from situation and take to another location as needed, dated 1/2/25.<br><br>The behavioral care plan failed to include all of Resident #45's specific behaviors such as physical aggression to other residents, the need for 15- minute checks, moments of paranoia or continuously giving food to another resident. The care plan also failed to indicate individualized interventions for staff to utilize during his/her behaviors. Additionally, the care plan focus indicates that Resident #45 is resistive to redirection, but failed to include alternative methods or means for staff to utilize in lieu of redirection.<br><br>During an interview on 8/13/25 at 10:09 A.M., the Administrator said that the facility had issued Resident #45 a 30-day notice after a resident-to-resident altercation, and after a female resident alleged that he/she had grabbed her buttocks inappropriately. The Administrator said that Resident #45 won the appeal and remained in the facility.<br><br>During an interview on 8/13/25 at 10:51 A.M., Unit Secretary #1 said that Resident #45 was very behavioral. When asked why he/she was placed on 15-minute checks, Unit Secretary #1 said she was not sure, but it may have been related to him/her constantly giving food to another resident which had caused the other resident to gain a large amount of weight.<br><br>During an interview on 8/13/25 at 10:56 A.M., CNA #7 said it was hard to keep track of Resident #45's incidents because he/she has had so many. CNA #7 said that Resident #45 is a very challenging resident on the unit.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 8/13/25 at 11:01 A.M., Unit Manager #1 said that Resident #45 does have a behavior care plan, but she didn't know if there was anything specific in there outlining his/her behaviors or interventions for staff to follow.<br><br>During an interview on 8/13/25 at 1:03 P.M., Social Worker #1 said that she does not write behavioral care plans. Social Worker #1 said that behavioral care plans should be specific and individualized to address resident needs.<br><br>During an interview on 8/14/25 at 8:06 A.M., Resident #45 appeared tired and agitated. Resident #45 said that he/she enjoyed seeing the SUD counselor and declined to continue the rest of the interview.<br><br>During an interview on 8/13/25 at 8:08 A.M., CNA #6 said that Resident #45 can be rude and very challenging.<br><br>During an interview on 8/14/25 at 12:51 P.M., the DON said that she would expect resident care plans to be individualized and address and resident specific behaviors and needs. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observation, record review, and interview, the facility failed to ensure physician's orders were implemented for two Residents (#40, #10), out of a total of 27 sampled residents. Specifically, the facility failed:1. For Resident #40, to ensure he/she received two tablets of Lactaid as ordered by the physician; and2. For Resident #10, to ensure a wander guard (a bracelet and monitor placed on a resident who is at risk for elopement, that is part of an alarm system to alert staff if a Resident is attempting to exit a unit or facility) was in place per the physician's order. Review of the facility's policy titled Self-Administration of Medications Policy, dated July 2015, indicated: Evaluate the resident's cognitive, physical and visual ability to self-administer medications, update the care plan for self-administration to include where the medications will be stored, documentation of self-administration and location of the drug administration. [NAME] the MAR (Medication Administration Record) for each medication being self-administered for daily compliance monitoring purposes. (Indicate that the resident has self-administered).<br><br>1. Resident #40 was admitted to the facility in June 2021 with diagnoses including hypertension and heart failure.<br><br>Review of the Minimum Data Set (MDS) Assessment, dated 6/6/25, indicated Resident #40 is cognitively intact evidenced by a score of 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam. The MDS also indicated Resident #40 requires assistance with ambulation and bathing.<br><br>During an interview on 8/12/25 at 8:22 A.M., Resident #40 was seated in the main dining room. Resident #40 pointed to a white pill on the dining room table and said it was his/her Lactaid tablet. Resident #40 said that staff give him/her the bottle which he/she keeps in his/her room and that he/she brings a tablet to meals. Resident #40 said that he/she used to take two tablets but the bottle goes quick and he/she started to take one tablet instead and it's been working.<br><br>Review of the Resident #40's Physician's Orders indicated:<br><br>-May self-administer Lactaid, ocean nasal spray, refresh eye drops and keep at bedside table locked draw (sic), dated 12/17/24.<br><br>-Lactaid Tab give two tablets orally with meals for lactose intolerance; unsupervised self-administration. May keep in locked bedside table drawer and self-administer, dated 9/7/22.<br><br>Review of the August 2025 MAR indicated Resident #40 self-administered two tablets of Lactaid three times a day from 8/1/25 through 8/13/25.<br><br>On 8/13/25 at 8:06 A.M., Resident #40 was in the dining room waiting for his/her breakfast Resident #40 pointed to one white tablet and told the surveyor that was his/her Lactaid tablet. Resident #40 said that he/she had told a nurse that he/she was only taking one tablet instead of two but could not recall who it was.<br><br>On 8/14/25 at 8:13 AM., the surveyor observed Resident #40 seated in the dining room, waiting for breakfast, with one Lactaid tablet on the table in front of him/her.<br><br>During an interview on 8/14/25 at 8:59 A.M., Nurse #3 said that Resident #40 keeps his/her<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medications in a white container in his/her room. Nurse #3 said that Resident #40 takes two Lactaid tablets twice a day, (contrary to the Resident's self-report of taking one tablet and the physician's order indicating he/she should be taking two tablets three times a day).<br><br>During an interview on 8/14/25 at 9:34 A.M., the Assistant Director of Nursing (ADON) said that residents should be assessed for self-administration of medications and that medications can be stored in their rooms or in the medication cart. The ADON said nursing staff should visualize residents self-administering their medications and then document on the MAR. The ADON was not aware that Resident #40 had been taking only one tablet of Lactaid instead of the ordered dosage, or that he/she had been bringing the tablet to the dining room and placing it on the table during the meal.<br><br>During an interview on 8/14/25 at 12:48 P.M., the Director of Nursing (DON) said that for residents who want to self-administer medications, staff are expected to assess and educate the residents and obtain a physician's order. The DON said medications should be administered in the dosage amount ordered by the physician.<br><br>2. Resident #10 was admitted to the facility in November 2024 with diagnoses that included metabolic encephalopathy, chronic obstructive pulmonary disease and acute respiratory failure.<br><br>Review of Resident #10's most recent MDS assessment, dated 5/30/25, indicated a BIMS score of 0 out of a possible 15, indicating severe cognitive impairment. The MDS also indicated that wandering occurred daily.<br><br>Review of Resident #10's active Physician's Orders indicated the following:<br><br>-Check Wander Guard Placement on Right Ankle. Code Alert: 9000-0434M. Expiration date 04-14-2026, every shift for safety, dated 4/22/25. [sic]<br><br>-check wander guard functioning, dated 4/22/25.<br><br>On 8/12/25 at 10:13 A.M., the surveyor observed Resident #10 in his/her wheelchair, there was no wander guard visible on his/her right ankle.<br><br>On 8/13/25 at 9:37 A.M., the surveyor observed Resident #10 sitting in his/her wheelchair in his/her room. The surveyor asked the Certified Nurse's Assistant (CNA) if the Resident had a wander guard on his/her right ankle. The CNA lifted the Resident's pant leg, and there was no visible wander guard in place.<br><br>Review of Resident #10's active behavior care plan, dated 4/22/25, indicated the following intervention:<br><br>-[Resident] has a new wander guard placed to [his/her] right ankle.<br><br>Review of the August 2025 Treatment Administration Record (TAR) indicated that the wander guard was checked and in place on 8/12 and 8/13 when the surveyor did not observe the wander guard as in place.<br><br>Review of Resident #10's nursing progress notes indicated the following:<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -A progress note, dated 4/22/25, that indicated, Resident alert, continues to have increased behavior of exiting. New order for Wander guard placed to the right ankle for safety protection. [sic]<br><br>During an interview and observation on 8/13/25 at 1:24 P.M., the surveyor and Nurse #4 observed Resident #10 in his/her room, there was no wander guard in place. Nurse #4 said that the Resident is unable to remove it him/herself, and that staff should be checking placement every shift as indicated in the physician's orders.<br><br>During an interview on 8/13/25 at 1:59 P.M., the Director of Nurses said that nurses should be checking every shift that the wander guard is in place. She said she would expect that physician's orders are followed and carried out.<br><br>During an interview on 8/14/25 at 11:05 A.M., the Medical Director said that he would expect physician's orders to be followed as written. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to implement an activity program of choice for one Resident (#12) out of a total sample of 27 residents. Findings include:Resident #12 was admitted to the facility in August 2023 with diagnoses including Alzheimer's Disease. Review of Resident #12's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 6 out of a possible 15, which indicated he/she has severe cognitive impairment. The MDS also indicated Resident #12 requires supervision for self-feeding tasks and is dependent on staff for all other self-care and mobility tasks. During an interview on 8/1/2/25 at 8/12/25 8:13 A.M., Resident #12 said he/she does not get out of bed and does not participate in activities. The Resident's television was on and there were no activity materials observed in the Resident's room. On 8/12/25, Resident #12 was observed lying in bed with the television on throughout the 7:00 A.M. and 3:00 P.M. shift and did not get out of bed. At no point did the surveyor observe an activity staff member invite the Resident to a group activity. During this time, the activities listed on the activity calendar were:-9:00 A.M. - Morning Visits/mails. This activity did not occur for Resident #12.-10:00 A.M., [NAME] Cart (beverages and snacks). This activity was not observed occurring on the unit.-10:30 A.M., Morning Stretch. Resident #12 did not participate in this group activity, and an activity staff was not observed doing this activity with the Resident in his/her room. -11:00 A.M., Task Table/Patio Time. Resident #12 did not participate in this activity, and no activity materials were observed on the table in the Resident's room. -2:00 P.M. Bean Bag Toss - Resident #12 did not participate in this group activity, and an activity staff was not observed doing this activity with the Resident in his/her room. On 8/13/25 Resident #12 was observed lying in bed with the television on throughout the 7:00 A.M. and 3:00 P.M. shift and did not get out of bed. At no point did the surveyor observe an activity staff member invite the Resident to a group activity. During this time, the activities listed on the activity calendar were:-9:00 A.M. - Morning Visits/mails. This activity did not occur for Resident #12.-10:00 A.M., [NAME] Cart (beverages and snacks). This activity was not observed occurring on the unit.-10:30 A.M., Morning Stretch. Resident #12 did not participate in this group activity, and an activity staff was not observed doing this activity with the Resident in his/her room. -2:00 P.M. Arts and Crafts - Resident #12 did not participate in this group activity, and an activity staff was not observed doing this activity with the Resident in his/her room. Review of Resident #12's activity preferences in the MDS indicated it was somewhat important for the Resident to have books, newspapers, magazines to read, to listen to music, to be with groups of people, and to get fresh air and go outside. Review of Resident #12's activity care plan indicated the following interventions: -As needed, remind and assist resident to higher level activities of interest. -Continue to educate resident of group programs of assessed interest by inviting resident and by explaining details of the program. -Disclose time, location and brief description of these programs -Encourage resident to present ideas for activity programs -Encourage resident to visit peers of similar capabilities -Explain purpose and encourage participation in resident council -Offer materials of interest for independent leisure activity.-Offer to go with resident just to take a look -Provide a calendar of events to assure awareness Review of Resident #12's fall care last revised 7/30/25 indicated the following intervention:- Invite, encourage, remind, escort to activity programs consistent with resident's interests to enhance physical strengthening needs. Review of Resident #12's impaired cognition care plan last revised 7/30/25 indicated the following intervention:-Encourage socialization and recreation activity Review of the activity progress note dated 7/16/25 indicated the Resident:-enjoys social contact with staff on a daily basis and continues to enjoy 1:1 visit with staff, music, watching television, and visiting with family.-Requires reminders to attend activities. -Needs assistance to participate in activities.-Enjoys large groups.-Is dependent on others for transport to activities.-Activity preferences include: religious, music, sing-a-long, active games, outside, sensory<br>(continued on next page) |

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| | 225298 | A. Building<br>B. Wing | 08/15/2025 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | groups, radio/music. -Television was not listed as a preferred activity. During an interview on 8/15/25 at 9:16 A.M., the Activities Director said the activity calendars are created based on resident preferences and abilities. The Activities Director said Resident #12 resides on a dementia unit and the activities on this unit are tailored to the cognitive abilities of the residents. The Activities Director said that for residents who are bed bound or do not get out of bed, the activities may include room visits, hand massages, exercises, activity materials that would leave in room, radio, magazines, and use of an iPAD for music. The Activities Director said Resident #12 loves to talk, likes to do light exercise with assistance, likes music and singing with or without music, magazines, picture books, and one-on-one. She said that Resident #12 has not gotten out of bed recently and that the activity staff should have gone into his/her room to do activities individually or to leave materials. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to ensure that one Resident (#52) received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the Resident's choices out of a total sample of 27 residents. Specifically, the facility did not provide a left-hand splint for Resident #27 to use for contracture management. Findings include:Resident #52 was admitted to the facility in January 2024 with diagnoses including dementia and left hand contracture. Review of Resident #52's most recent Minimum Data Set (MDS) dated [DATE], indicated Resident #52 had a Brief Interview for Mental Status (BIMS) score of 1 out of a possible 15, which indicated the Resident has severe cognitive impairment. The MDS also indicated Resident #52 has an impairment in range of motion in the left hand and requires supervision for eating. On 8/12/25 at 9:10 A.M., Resident #52 was observed lying in bed. His/her morning care had not yet been completed, and his/her left hand was observed lying on the bed without an orthotic (splint) on. There was no orthotic observed near the bed or in the room. On 8/13/25 at 7:28 A.M., Resident #52 was observed lying in bed. His/her morning care had not yet been completed, and his/her left hand was observed lying on the bed without an orthotic on. There was no orthotic observed near the bed or in the room. On 8/14/25 at 6:25 A.M., Resident #52 was observed lying in bed. His/her morning care had not yet been completed, and his/her left hand was observed lying on the bed without an orthotic on. There was an orthotic observed near on the bottom shelf of the bedside table. The straps on the orthotic were closed, indicating it had not been used. Review of the occupational therapy Discharge summary, dated [DATE], indicated the following:-Discharge recommendation: patient to wear (his/her) left hand orthotic overnight for management of dystonia and to reduce risk of contracture. -Patient response progress and response to treatment: patient exhibits positive response to interventions to alleviate dystonia for improved postural stability while seated. Reports good fit and comfort while using (his/her) left hand orthotic to manage dystonia and reduce risk of contracture. Review of Resident #52's physician orders indicated the following order initiated on 3/11/25:-Splint to be worn on left hand overnight. Apply with PM (night) care. Remove with AM (morning) care. Check skin each shift. Review of Resident #52's dystonia care plan, last revised 3/18/25, indicated the following intervention:-Patient to wear resting hand orthotic on (his/her) left hand overnight, Apply during PM care. Remove during AM care. Check skin daily each shift. [sic] During an interview on 8/14/25 at 6:40 A.M., Resident #52 said he/she is supposed to wear a splint at night and has not been wearing it. The Resident said he/she is agreeable to wearing the splint. During an interview on 8/14/25 at 6:35 A.M., Nurse #2 said she works the overnight shift and Resident #52 has an order to wear a left-hand splint while sleeping. Nurse #2 said she did not put the splint on Resident #52 last night. During an interview on 8/14/25 at 6:41 A.M., Certified Nursing Assistant #2 said Resident #52 has a hand splint that he/she is supposed to wear at night, and she did not see the Resident wearing the splint last night. During an interview on 8/14/2025 at 11:33 A.M., the Director of Nursing said Resident #52 has a left-hand contracture and was provided with a splint from the therapy department for contracture management. The Director of Nursing said Resident #52 should be wearing the splint at night as ordered. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to implement fall interventions to potentially prevent falls for two Residents (#52 and #22) out of a total sample of 27 residents. Findings include:<br><br>1. Resident #52 was admitted to the facility in January 2024 with diagnoses including dementia and repeated falls.<br><br>Review of Resident #52's most recent Minimum Data Set (MDS) dated [DATE], indicated Resident #52 had a Brief Interview for Mental Status (BIMS) score of 1 out of a possible 15, which indicated the Resident has severe cognitive impairment. The MDS also indicated Resident #52 has an impairment in range of motion in the left hand and requires supervision for eating.<br><br>Review of Resident #52's physician orders indicated the following orders:<br><br>-bed alarm - check placement and function q (every) shift, every shift for preventative maintenance s/p (status post) fall, 3/13/24.<br><br>-chair alarm - check placement and function q (every) shift, every shift for preventative maintenance s/p (status post) fall, 3/13/24.<br><br>Review of Resident #52's medical record indicated the Resident had sustained 4 falls in the past year.<br><br>a. A nursing note dated 9/21/24 indicated the following:-Resident had a witnessed fall, (he/she) slid off from (his/her) w/chair. (He/she) was observed sitting on the floor on (his/her) buttocks. resident was getting agitated and impulsive with redirection and insisted on standing up on (his/her) own. no injuries noted, ROM (range of motion) at baseline, denies pain, responsible parties notified.<br><br>Review of the incident report for this fall failed to indicate the Resident's chair alarm was in place and functioning at the time of the fall.<br><br>b. A nursing note dated 10/23/24 indicated the following:<br><br>-Resident was observed on the floor in (his/her) room next to (his/her) roommate bed by a CNA (certified nursing assistant). (He/she) was lying down. It was unwitnessed fall. When asked what happened. Resident stated (he/she) was going to the bathroom when (he/she) lost balance and fell.<br><br>Review of the incident report for this fall failed to indicate the Resident's bed alarm was in place and functioning at the time of the fall.<br><br>c. A nursing note dated 10/26/25 indicated the following:<br><br>-Resident was found sitting on the floor on (his/her) buttocks, resident alert and responsive, No signs of distress or SOB (shortness of breath), denies pain or hitting (his/her) head. Resident has intact bruise on (his/her) back. non skid socks on, chair alarm on, safety maintained.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the incident report for this fall indicated the Resident was found sitting on floor next to his/her bed as he/she was attempting to reach down to get his/her shoes. The incident report said a CNA was alerted of the fall due to a visitor seeing the Resident on the floor and failed to indicate the Resident's alarm was alerting the staff of his/her movement.<br><br>d. A nursing note dated 7/12/25 indicated the following:<br><br>-This writer was called into the resident's room by housekeeping staff who observed the resident on the floor. Resident was found lying supine on the bedside. Resident stated (he/she) slid off the bed.<br><br>Review of the incident report for this fall indicated that at the time of this fall the Resident's alarm was not on and did not sound.<br><br>On 8/12/2025 at 9:10 A.M., Resident #52 was observed lying in bed. A bed alarm was observed on the floor next to the Resident's bed and the light indicating it was functional was not on.<br><br>On 8/12/2025 at 11:30 A.M., Resident #52 was observed sitting in his/her wheelchair in the dining room. The Resident's chair did not have a chair alarm on it.<br><br>On 8/13/2025 at 6:58 A.M., 7:41 A.M., and 8:42 A.M., Resident #52 was observed lying in bed. A bed alarm was observed on the floor next to the Resident's bed and the light indicating it was functional was not on.<br><br>On 8/13/2025 at 9:53 A.M., Resident #52 was observed sitting in his/her wheelchair in the dining room. The Resident's chair did not have a chair alarm on it.<br><br>During an interview on 8/13/2025 at 9:53 A.M., the Assistant Director of Nursing (ADON) said Resident #52 has had numerous falls and was provided with both a chair and a bed alarm as a fall intervention. The Assistant Director of Nursing then observed Resident #52 in the dining room and confirmed the Resident did not have a chair alarm on his/her wheelchair. The surveyor and Assistant Director of Nursing then went to the Resident's room and observed the bed alarm which the Assistant Director of Nursing said was not functioning and possibly had a dead battery. The Assistant Director of Nursing said that these alarms should be checked for placement and functioning every shift.<br><br>During an interview on 8/13/2025 at 1:53 P.M., the Director of Nursing said after a resident falls the facility implements a new fall intervention for the prevention of further falls and these interventions should be followed at all times. The Director of Nursing said that in reviewing the incident report for Resident #52's falls, the staff did not indicate the alarms were in place and functioning at the time of the falls and the alarms must not have been implemented as they should have been. She said that the witness statements in the incident reports are accurate so if the report says no alarm, then there was no alarm in place. The Director of Nursing said Resident #52's bed and chair alarms should be checked every shift for placement and function, and she was unaware Resident #52 did not have a chair alarm on his/her wheelchair or that the bed alarm was not functioning.<br><br>2. Resident #22 was admitted to the facility in May 2025 with diagnoses of falls resulting in left pubis fracture and bipolar disorder.<br><br>Review of Resident #22's most recent Minimum Data Set (MDS) assessment, dated 7/9/25, indicated the Resident had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | (BIMS) score of 12 out of 15. The MDS also indicated Resident #22 required substantial to moderate assistance with self-care and mobility tasks.<br><br>Review of Resident #22's medical record indicated the Resident had sustained 4 falls in the past three months.<br><br>Review of Resident #22's fall care plan indicated the following interventions:<br><br>-Low bed, call light. Rehab/mental health screens, initiated 5/7/25.<br><br>-Fall mats to both sides of bed, initiated 6/6/25.<br><br>-15-minute checks x 48 hours, initiated 6/9/25.<br><br>-Bed, chair, fall mat, and motion alarms, initiated 7/15/25.<br><br>-Close observation, initiated 8/14/25.<br><br>On 8/12/25 at 7:37 A.M., Resident #22 was observed lying in bed. A fall mat was observed on the floor next to the right side of bed. There were no alarms in the room.<br><br>On 8/13/25 at 11:44 A.M., Resident #22 was observed lying in bed. A fall mat was observed on the floor next to the right side of bed. There were no alarms in the room.<br><br>On 8/13/25 at 12:31 P.M., Resident #22 was observed sitting up in bed eating lunch. A fall mat to the right side of bed was pushed aside to accommodate the overbed table. There were no alarms in the room.<br><br>On 8/14/25 at 7:35 A.M., Resident #22 was observed lying in bed. A fall mat was observed on the floor next to the right side of bed. There were no alarms in the room.<br><br>Review of Resident #22's incident report dated 8/2/25 indicated the following:<br><br>- 'Resident sitting at the dining table eating his/her breakfast, he/she was observed standing fast from the chair, lost balance, and landed on his/her left side'. Review of the incident report for this fall failed to indicate the Resident's chair alarm was in place and functioning at the time of the fall. The report failed to mention an alarm being in place on the chair or that it had sounded.<br><br>Review of Resident #22's incident report dated 8/11/25 indicated the following:<br><br>- 'Around 8 P.M., CNA on duty notified nurse that Resident was on the floor. As reported by CNA, Resident told me he/she fell, and I found him/her on his/her knees. On assessment by nurse Resident was found partly in bed with both his/her legs dangling out of bed.' Review of the incident report for this fall failed to indicate the Resident's chair alarm was in place and functioning at the time of the fall or that bilateral fall mats were in place. The report failed to mention an alarm being in place in the room or on the bed or that it had sounded.<br><br>Review of Resident #22's Rehab Screen, dated 8/12/25, recommended bed at lowest level. Bilateral floor mats. Resident supervised in common areas when displaying increased agitation to reduce risk<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | of falls.<br><br>During an interview on 8/13/2025 at 1:53 P.M., the Director of Nursing said after a resident falls the facility implements a new fall intervention for the prevention of further falls and these interventions should be always followed. She said that the witness statements in the incident reports are accurate so if the report says no alarm, then there is no alarm in place.<br><br>During an interview on 8/14/25 at 12:56 P.M., The Director of Nursing said that the care plan is reviewed after each fall and that she makes rounds to make sure interventions are in place. She said that she was not aware that Resident #22's plan of care indicated bilateral fall mats were to be used. She said that the fall interventions of bilateral fall mats in the care plan should be followed, but were not. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on observations, interviews and record review, the facility failed to maintain professional standards in the management and care for urinary catheter devices for one Resident (#81) out of a total sample of 27 residents. Specifically, the facility failed to ensure the urinary catheter drainage bag was not placed in direct contact with the floor. Findings include:Review of facility policy, titled Urinary Catheter Care, dated April 2015, indicated the following:-Policy: Routine urinary catheter care will be provided by trained CNAs [Certified Nursing Assistants] as necessary, to keep the catheter insertion site clean in order to prevent infection and other complications. Resident #81 was admitted to the facility in September 2023 with diagnoses that included weakness and atrial fibrillation. Review of Resident #81's most recent Minimum Data Set (MDS) Assessment, dated 5/30/25, indicated that the Resident was unable to participate in a Brief Interview for Mental Status (BIMS) exam and was assessed by staff as being severely impaired with cognitive skills for daily decision making. The MDS further indicated the use of an indwelling urinary catheter. On 8/12/25 at 7:42 A.M., the surveyor observed Resident #81 awake in bed. The surveyor observed a urinary catheter drainage bag without a privacy bag present resting in direct contact with the floor On 8/13/25at 6:57 A.M., the surveyor observed Resident #81 sleeping in bed. The surveyor observed a urinary catheter drainage bag with a privacy bag present resting in direct contact with the floor. On 8/13/25 at 8:46 A.M., the surveyor observed a nurse assist the Resident with breakfast and then leave the Resident's room. The Resident remained in bed, and the urinary catheter drainage bag remained in direct contact with the floor. On 8/13/25 at 10:27 A.M., the surveyor observed the Resident in bed, dressed. The urinary catheter drainage bag remained without a privacy bag and remained resting in direct contact with the floor without any barrier between the drainage bag and the floor. Review of Resident #81's physician's orders indicated the following: -Foley catheter care every shift, dated 2/26/25.-Change foley catheter bag weekly every sun night, dated 6/15/25. During an interview on 8/14/25 at 6:55 A.M., Nurse #2 said that catheter drainage bags should not be resting on the floor. She said that if the drainage bag is resting on the floor, it would be an infection control concern. She further said that staff should check frequently that it isn't on the floor. During an interview on 8/14/25 at 7:01 A.M., Certified Nurse's Assistant (CNA) #8 and CNA #9: said that a resident's urinary drainage bag should have a privacy cover and not be resting directly on the floor. They said that if the drainage bag is touching floor would create a risk for infection. During an interview on 8/14/25 at 9:57 A.M., the Director of Nurses said that a urinary drainage bag should be hanging on the side of the bed, below the level of the bladder, but it should not be in contact with the floor due to infection control concerns and risk for infection. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to provide nutritional intervention for one Resident (#12) with a significant weight loss out of a total sample of 27 residents. Findings include: Review of the facility policy titled, Weights, undated, indicated the following:-A weight loss/gain of 3 pounds or more on a resident weighing 100 pounds or less and weight loss/gain of 5 pounds or more on a resident weighing 100 pounds or more requires a reweigh for verification. A reweigh is done on the same scale, with a licensed nurse present.-if a significant weight loss/gain is identified (> 5% in 30 days or > 10% in six months), the IDT (interdisciplinary team), dietitian, physician and family are notified.-All residents with a significant weight loss are reviewed by the interdisciplinary team and the resident/responsible party and interventions implemented as appropriate and are monitored weekly. Resident #12 was admitted to the facility in August 2023 with diagnoses that included dysphagia, diabetes, and Alzheimer's Disease. Review of Resident #12's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 6 out of a possible 15, which indicated he/she has severe cognitive impairment. The MDS also indicated Resident #12 required supervision for self-feeding tasks and was dependent on staff for all other self-care and mobility tasks. Review of Resident #12's weights indicated that on 7/14/25, the Resident weighed 257.2 lbs. (pounds) and on 8/6/25, the Resident weighed 240.4 lbs. which is a -6.53% significant weight loss. During an interview on 8/14/25 at 8:38 A.M., Resident #12 said he/she was unaware he/she had lost any weight, and no one had come to speak with him/her about it. Review of Resident #12's medical record failed to indicate the following:-A re-weight was obtained to validate the weight loss.-The physician or Dietitian were notified of the weight loss.-The Dietitian reviewed Resident #12's weight loss and addressed the loss. -A new intervention for further prevention of weight loss was initiated. -Resident #12 was followed by the risk management team. Review of Resident #12's nutritional care plan initiated on 8/7/25 indicated the following interventions:-Allow Resident sufficient time to eat.-Monitor and evaluate energy intake, food/beverage via food records and observation.-Monitor and evaluate weight changes.-Provide medical food supplements. Review of the Certified Nursing Assistant (CNA) documentation indicated the staff failed to monitor Resident #12's food intake for 4 meals (out of a possible 21) since the weight loss occurred. During an interview on 8/14/25 at 9:07 A.M., Nurse #1 said all residents are weighed according to the physician orders and if a significant change in weight occurs, the nursing staff should obtain a reweight within 24-48 hours to validate the significant change. Nurse #1 said if the significant weight change is validated, the dietitian, physician, and interdisciplinary team should be notified and an intervention put in place immediately to prevent further weight loss. Nurse #1 said she works full time on Resident #12's unit and was unaware the Resident had lost any weight. During an interview on 8/14/25 at 10:23 A.M., the Registered Dietitian (RD) said she works at the facility two days a week and reviews a weight report to follow all residents' weights and to identify any weight changes that occurred. The RD said the facility also has weekly risk management meetings and she is also notified of a resident's significant weight change during these meetings. The RD said if a resident were to have a significant weight loss, which would be over 5% in one month, the nursing staff should complete a reweight of the resident within 24-48 hours to validate the loss. The RD said if the weight loss is validated, she should be notified by the nursing staff, and a nutritional intervention should be put in place immediately and waiting a week to do so would be too long. The RD said she often finds weight loss herself by looking at the report and the nursing staff does not always notify her of significant weight changes in the facility. When reviewing Resident #12's medical record with the surveyor, the RD confirmed the Resident's significant weight loss and said she was never notified of the loss, that the Resident was never discussed in risk meeting, that a reweight was never obtained as it should have been and that an intervention was never put in place as it should<br>(continued on next page) |

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| Northwood Rehabilitation & Healthcare Center | 1010 Varnum Avenue<br>Lowell, MA 01854 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | have been. The RD said she would have to assess Resident #12 because she felt the Resident would benefit from increased supplementation. During an interview on 8/14/25 at 11:03 A.M., Physician #1 said he was not aware of Resident #12's weight loss and had not been notified by the facility. During an interview on 8/14/2025 at 11:33 A.M., the Director of Nursing said all residents are weighed monthly unless otherwise ordered, and the facility monitors these weights to check for any significant weight changes. The Director of Nursing said if a significant weight change occurs, the facility must complete a reweight of the resident, notify the physician and dietitian and put a new nutritional intervention in place immediately. The Director of Nursing said Resident #12 did have a significant weight loss and was unsure why a nutritional care plan was created but a new intervention not put in place. The Director of Nursing said she would have expected a new nutritional intervention to have been put in place for Resident #12 immediately and could not say why one was not. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>Based on observation, interview, and record review, the facility failed to provide care and maintenance of a Peripherally Inserted Central Catheter (PICC: a flexible tube inserted through a vein in one's arm and passed through to the larger veins near the heart, used to deliver medications intravenously [IV] ), consistent with professional standards of practice for one Resident (#131), out of a total sample of 27 residents. Specifically, for Resident #131, the facility failed to obtain weekly measurements for the external length of Resident #131's PICC line to ensure the PICC line had not migrated (moved from the heart to another area, which could have a significant impact on treatment, or cause serious harm). Findings include: Review of the Lippincott Manual of Nursing Practice, 11th Edition, dated 2021, included the following for documentation relative to PICC line migration and dressing changes: Use a sterile measuring tape or incremental markings on the catheter to measure the external length of the catheter from hub to skin entry to make sure that the catheter hasn't migrated. Resident #131 was admitted to the facility in August 2025 with diagnoses that included bacteremia, methicillin resistant staphylococcus aureus (MRSA), and urinary tract infection (UTI).The most recent Minimum Data Set (MDS) assessment has not been completed. Review of Resident #131's active physician orders, failed to indicate orders to measure external length of the PICC line. Review of Resident #131's baseline plan of care, dated 8/7/25, failed to indicate care of PICC line and need for measurements with dressing changes. Review of Resident #131's nursing progress notes and assessments from 8/6/25 through 8/14/25 failed to indicate that nursing obtained PICC line measurements. During an interview on 8/14/25 at 1:07 P.M., the Director of Nursing and the Regional Clinical Manager/Chief Nurse Specialist said the PICC line measurements should be obtained weekly with the PICC line dressing change to monitor for catheter migration which could lead to complications including infection. The measurements should be documented in a nursing note. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>Based on record review, and interviews, the facility failed to provide care and services consistent with professional standards of practice for one Resident (#11) who required renal dialysis (a life sustaining treatment that helps the body remove extra fluids and waste products from the blood when the kidneys are not able to) out of a total sample of 27 residents. Specifically, the facility failed to ensure nursing assessments, including the assessment of the dialysis access site were performed when Resident #11 returned from dialysis treatments. Findings include:Review of the facility policy titled ?Hemodialysis', dated April 2015, indicated care of arteriovenous (AV) fistula (how patients are connected to a dialysis machine):-Assess AV fistula every shift for the following and document:a. pain.b. signs and symptoms of infection (drainage, swelling, tenderness).c. scab formation.d. color, motion, and sensitivity of access arm.e. palpate fistula for a thrill (vibration felt over fistula).f. auscultate fistula for a bruit (whooshing heard over fistula).-Documentation of the assessment will be kept in the medical record. Resident #11 was admitted to the facility in July 2024 with diagnoses including End Stage Renal Disease (ESRD) and Diabetes. Review of the most recent Minimum Data Set (MDS) Assessment, dated 8/7/25, indicated that Resident #11 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and that Resident #11 was on dialysis. Review of the August 2025 Physician's orders failed to indicate any orders to assess Resident #11's AV fistula every shift or upon return from dialysis. Review of the August 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) failed to indicate any orders to assess Resident #11's AV fistula every shift or upon return from dialysis. Review of Resident #11's nursing progress notes from 7/16/25 through 8/14/25 failed to include every shift assessment of his/her AV fistula or an assessment upon Resident #11's return from dialysis. Review of the Renal Dialysis Care Plan, revised 8/6/24, indicated Resident #11 received hemodialysis on Mondays, Wednesdays and Fridays for End Stage Renal Disease. The plan of care included the following interventions:-after dialysis resident may have low blood pressure (BP), dehydration signs/symptoms, muscle cramps, nausea, vomiting, headache, or pain in the back or chest.-fever, abnormal heart rhythms, air embolism, bleeding, infections are potential complications of hemodialysis.-monitor thrill and bruit. [part of the assessment to check function of an AV fistula and ensure proper blood flow. During an interview on 8/12/25 at 7:41 A.M., Resident #11 pointed to his/her left lower arm fistula when the surveyor asked to view his/her access site. During an interview on 08/14/25 at 1:11 P.M., the Director of Nursing and Regional Clinical Manager/Chief Nurse Specialist said there should be an order for assessment of the dialysis access of Resident #11 upon return from dialysis and that should be documented in the medical record. |

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| F 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that the resident and his/her doctor meet face-to-face at all required visits.<br><br>Based on record review and interview, the facility failed to ensure one Resident (#86) was seen by a physician at least once every 30 days for the first 90 days after admission. Findings include:Resident #86 was admitted to the facility in May 2025 with diagnoses that included hallucinations and chronic kidney disease. Review of Resident #86's most recent Minimum Data Set (MDS) Assessment, dated 5/14/25, indicated that the Resident could not participate in a Brief Interview for Mental Status Exam and was assessed by staff to have severe cognitive impairment. Review of the paper medical record and electronic medical record indicated one physician's progress note, dated 5/9/25. Further review of the entire medical record failed to indicate another physician's visit since 5/9/25. During an interview on 8/13/25 at 1:50 P.M., the Chief Nurse Specialist provided the requested physician's visit notes. She said that the only physician's note in the medical record for the Resident was from 5/9/25. During an interview on 8/14/25 at 10:02 A.M., The Director of Nurses said that she would expect a new Resident to be seen within 48 hours of admission and then at least every 30 days for the first 90 days after that. The Director of Nurses said that she would call the physician's office to see if there have been other visits with the Resident that are not in the medical record. The Director of Nurses also said that all notes should be put into the medical record timely so that the record is complete. During an interview on 8/14/25 at 11:06 A.M., the Medical Director (who is not the physician for this Resident) said that he would expect visits upon admission every 30 days for the first 90 days by a physician or a Nurse Practitioner. During a follow up interview on 8/15/25 at 7:57 A.M., the Director of Nurses said that Resident #86's physician is on vacation, and she has not heard back or received any other notes from the physician's office. During an interview on 8/15/25 at 8:59 A.M. the Administrator said he would expect physicians and Nurse Practitioners to see residents per the regulations, including every 30 days for the first 90 days after admission. On 8/19/25 the facility sent the surveyor more physician visit notes for Resident #86, dated 7/18/25 and 8/18/25, which were 72 and 103 days after the Resident's admission to the facility. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observe each nurse aide's job performance and give regular training.<br><br>Based on record review and interview, the facility failed to complete annual Certified Nurse Aide (CNA) performance reviews for five of five sampled CNA's. Findings include:During the review of five CNA employee records on 8/14/25 at 11:05 A.M., the surveyor noted that five of five sampled CNAs did not receive annual performance reviews. During an interview on 8/14/25 at 11:33 A.M., the Human Resource representative said she provides the Unit Managers with the annual performance review paperwork, and once completed she files them in the employees' file. The Human Resource representative said annual performance reviews for this year have not been completed. During an interview with the Corporate Nurse on 8/14/25 at 12:31 P.M., the above concerns were reviewed. The Corporate Nurse said performance reviews should be completed on an annual basis. The Corporate Nurse said we are currently working on getting all performance reviews completed. |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure ongoing behavioral health services were provided for Resident #45. Specifically, the facility failed to ensure the behavioral health provider completed follow up services after the introduction of a new medication and failed to alert the provider when his/her behaviors continued and was sent out on a section-12 hospitalization, (an involuntary psychiatric hospitalization). Findings include: Review of the facility's Consultant Services policy, dated April 2015 indicated: [The Facility] will identify and facilitate consultant services to meet the resident's needs to ensure optimum care for each resident/patient through consultant services.The policy did not include information related to communication of resident status from the facility to the provider.Resident #45 was admitted to the facility in December 2024 with diagnoses including bipolar disorder and psychoactive substance abuse.Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #45 is cognitively intact evidenced by a score of 15 out of 15 on the Brief Interview for Mental Status Exam (BIMS). The MDS also indicated Resident #45 had verbal and physical behaviors and also behaviors of rejecting care. Review of Resident #45's care plans indicated:Focus: Resident #45 has a diagnosis of depression and bipolar disorder, initiated 12/23/24.Interventions: Provide individual support, listen, empathize. Encourage him/her to remain on topic. Encourage him/her to reach out to supportive people in his/her life. Talk about things he/she enjoys. Assess environment and suggest change if needed. Utilize SW (social worker) and psych services as needed. Focus: Behavior Problem related to diagnosis of Bipolar Disorder. He/she can be verbally abusive: curses and screams at others. He/she is resistive to care and redirection and may wander, initiated 1/2/25, revised 7/16/25. Interventions: Explain care in advance, in terms resident understands. If reasonable, discuss behavior, explain/reinforce why behavior is unacceptable. Intervene as needed to promote the rights & safety of others; approach in calm manner, divert attention, remove from situation and take to another location as needed, 1/2/25.Focus: Resident #45 has a diagnosis of psychoactive substance abuse, initiated 7/14/25. Interventions: Provide individual/group therapy/Psychoeducation groups. Provide community resources and referrals for aftercare as desired. 7/14/25Review of the Behavioral Health Nurse Practitioner (NP) note dated 6/13/25 indicated: Patient seen today for routine assessment and medication review. Mood is unstable with no acute distress. Nursing reports new concerns regarding pt irritability, impulsivity, aggression but his/her sleep is good. Pt reported being aggressive toward another resident but denies and becomes agitated. Continue with supportive care. Start Depakote (a medication used to treat mood disorders and seizures) 250 mg by mouth once a day and patient continues to benefit from psychiatric medications. Monitor mood, document behaviors and contact [behavioral health services] if needed. Follow up: 1-4 weeks. Review of the physician's orders indicated Depakote was initiated as recommended by the Behavioral Health Nurse Practitioner. The clinical record failed to indicate anyone from Behavioral Health Services completed a follow up visit in the 1-4 weeks as indicated in the 6/13/25 note or that Resident #45 declined or refused any visits. Review of Resident #45's progress notes indicated:-6/24/25: Refuses to leave door open to his/her room, refuses to have light on when roommate being attended by nurse. Yells and curses at staff. When door is opened, he/she gets oob (out of bed) and shuts door. Verbal redirection with no effect at all.-6/26/25: This writer has had multiple daily conversations with Resident #45 about doing the right thing and treating all with respect. Resident's intentions in conversation are good, yet his/her follow thru with staff and other residents continues to be demanding, righteous and confrontational.Resident #45 seems incapable to realize that his/her actions are not positive or appropriate. -6/27/25: Verbally abusive to a staff member times 3. Verbal redirection without effect. -6/27/25: Resident #45 went outside quickly got in van and would not get out even after driver told him/her that he was not able to<br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | take him/her. Driver had to take d/t (due to) he/she would not get out of the van. -6/30/25: Nurse Practitioner (NP) Note: PT was evaluated by psych on 6/13 due to altercation with another resident. Patient has had increased irritability as well.-7/1/25: Late note for 6/28/25: Resident was requesting for medication that was not on his/her medication list, when writer asked what was going on with him/her if he/she was having any discomfort, he/she got very upset and could not gave (sic) the nurse a chance to administer other resident medications. Redirected with negative effects. -7/10/25: Continues to give another resident food that he/she should not have. Resident #45 has been told this so many times but continues to give him/her food.-7/16/25: When Resident #45 was spoken to about feeding another resident he/she had very vulgar language i.e. go F yourself. I will effing do what I want. Verbally redirected without effect. -7/17/28: It has been reported by CNA and other residents that Resident #45 was non-compliant during cigarette breaks, grabbing and pocketing others' cigarettes. Resident #45 denies incident. He/she has been asked to check belongings but refused. Nursing will continue offering education as needed. -7/20/25: At approximately 11:30 AM, CNA called me to [Resident #45's room]. Upon arrival, I found Resident #45 cutting another resident's hair with scissors. On the table were a manual and electric shaver that belonged to his/her roommate. When asked to stop, Resident #45 continued cutting. The CNA and I relocated to other resident back to his/her room. We have asked Resident #45 to return the scissors for safety reasons but he/she refused. The lead CNA attempted to redirect him/her without success. NP on call has been notified, ordering a Section 12. Resident #45 was transferred to [the hospital] via stretcher, 2 cops were present. DON (Director of Nursing) and Administrator made aware. -7/22/25: Nurse Practitioner Note: Over the weekend patient was seen by staff cutting another resident's hair. When asked to give the staff his/her scissors, patent refused and became agitated. Patient was sent out for further psych evaluation. Patient was cleared by psych to return back to [facility] the same day. On today's exam, patient agitated that he/she had to give his/her scissors to staff. Discussed importance of not cutting another patient's hair due to safety concerns. -7/24/25: PT noted to be intrusive into pt's rooms today. When asked to leave stated I can be wherever I want! Swearing at nursing staff.-7/31/25: Again after multiple times not to give extra food to another resident he/she gave him/her more ice cream and cookies. Verbal redirection without effect. -8/12/25: Using abusive words on staff, calling them liars. Distracting other residents from getting care stating, don't believe what they are saying to you.The clinical record failed to indicate that Behavioral Health Services was notified of Resident #45's continued behaviors or section 12 hospitalization on 7/20/25.During an interview on 8/13/25 at 10:51 A.M., Unit Secretary #1 said that Resident #45 was very behavioral on the unit and could be difficult to manage. During an interview on 8/13/25 at 10:56 A.M., CNA #7 said it was hard to keep track of Resident #45 incidents because there has been so many. CNA #7 said that Resident #45 is a very challenging resident on the unit. During an interview on 8/13/25 at 11:01 A.M., Unit Manager #1 said that Resident #45 is very behavioral on the unit. Unit Manager #1 said that he/she had last been seen by psych services in June 2025 when he/she was put on Depakote. Unit Manager #1 said the Depakote doesn't seem to be working. Unit Manager #1 said that behavioral health services would only have been notified of the lack of progress with the psych medications or his/her section 12 hospitalization if the staff documented it in the referral book. When asked if staff should be communicating with behavioral health services regarding Resident #45's ongoing behaviors and July 2025 hospitalization, Unit Manager #1 said I can put it in now. Review of the unit's psychiatric referral book from June 2025 through August 2025 indicated no requests for Resident #45 to be seen until 8/13/25. During an interview on 8/13/25 at 1:03 P.M., Social Worker #1 said Resident #45 is very behavioral and said that behavioral health services is involved and was not aware he/she had not been seen by them since June 2025. Social Worker #1 said nursing staff should have communicated Resident #45's ongoing behaviors and section-12 hospitalization to behavioral health services by putting that information in the referral book. During an interview on 8/14/25 at 8:06 A.M., Resident #45 appeared tired and agitated. Resident #45 said that he/she enjoyed seeing the SUDS<br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | (Substance Use Disorder) Counselor and declined to continue the rest of the interview. During an interview on 8/13/25 at 8:08 A.M., CNA #6 said that Resident #45 can be rude and very challenging. The Behavioral Health Nurse Practitioner was unavailable for interview.During an interview on 8/14/25 at 11:18 A.M., the Behavioral Health Services Director (BHSD), she said that the Behavioral Health Services Nurse Practitioner (NP) was away, but comes out weekly to the facility. The BHSD said that the NP will have a schedule for residents on caseload and determine the frequency of follow up if needed. The BHSD said they also review the referral book for updates from staff. The BHSD was not aware that Resident #45 had not been seen by the Behavioral Health NP since 6/13/25 despite the 6/13/25 note indicating the need for follow up in 1-4 weeks. The BHSD said she would have expected facility staff to alert the NP and communicate ongoing behaviors and section-12 hospitalizations because there would be no other way for their staff to know unless they happened to find it in a progress note. During an interview on 8/14/25 at 12:51 P.M., The Director of Nursing (DON) was not aware that Resident #45 had not received any visits from Behavioral Health Services since 6/13/25. The DON said that she would expect nursing staff to communicate ongoing resident behaviors and psychiatric hospitalizations to behavioral health services. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal laws. Specifically:1. The facility failed to ensure medications were dated once opened according to manufacturer's guidelines in one of three medication carts observed.2. The facility failed to ensure medications were stored securely in a resident room for one Resident (#40) out of a total of 27 sampled residents. Findings include: Review of the Medication Storage Room/Medication Cart Policy, dated February 2018, indicated: Licensed personnel will be responsible to check expiration dates on ordered medications, house stock medications, and supplies. Medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel.<br><br>Review of the Self-Administration of Medications Policy dated July 2015. indicated: Evaluate the resident's cognitive, physical and visual ability to self-administer medications, Update the care plan for self-medication to include where the medications will be stored, documentation of self-administration and location of the drug administration.<br><br>1. On 8/13/25 at 8:51 A.M., the surveyor and Unit Manager #2 observed the following in the B Wing side two medication cart:<br><br>- One fluticasone propionate nasal spray, opened and undated.<br><br>- One advair diskus inhaler, opened and undated.<br><br>- One trelegy ellipta inhaler, opened and undated.<br><br>During a follow up interview on 8/13/25 at 8:51 A.M., Unit Manager #2 said the fluticasone propionate nasal spray, advair diskus inhaler, and trellegy inhaler were all opened. Unit Manager 2 said these medications have shortened expiration dates once opened and should have been dated but were not.<br><br>During an interview on 8/13/25 at 11:09 A.M., the Director of Nursing (DON) said the fluticasone propionate nasal spray advair diskus inhaler, and trellegy inhaler have shortened expiration dates once opened and should have been dated once opened.<br><br>2. Resident #40 was admitted to the facility in June 2021 with diagnoses including hypertension and heart failure.<br><br>Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #40 is cognitively intact as evidenced by a score of 14 out of a possible 15 on the Brief Interview for Mental Status Exam. The MDS also indicated Resident #40 requires assistance with ambulation and bathing.<br><br>During an interview on 8/12/25 at 8:22 A.M., Resident #40 was seated in the main dining room. Resident #40 pointed to a white pill on the dining room table and said it was his/her Lactaid tablet. Resident #40 said that staff give her the bottle which he/she keeps in his/her room and that she brings a tablet to meals. Resident #40 said that he/she used to take two tablets but the bottle goes quick and he/she started to take one tablet instead and it's been working.<br>(continued on next page) |

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| | 225298 | A. Building<br>B. Wing | 08/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Northwood Rehabilitation & Healthcare Center | 1010 Varnum Avenue<br>Lowell, MA 01854 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Resident #40's physician order dated 12/17/24 indicated: May self-administer Lactaid, ocean nasal spray, refresh eye drops and keep at bedside table locked draw. (sic)<br><br>During an interview on 8/12/25 at 9:04 A.M., Resident #40 was seated in his/her room. Resident #40 showed the surveyor a small ceramic container which held a bottle labeled Dairy Relief; Lactase Enzyme Supplement and two bottles of refresh eye drops.<br><br>On 8/13/25 at 7:54 A.M., the surveyor observed the bottle of Lactase, and two bottles of refresh eye drops in the container on Resident #40's overbed table and a bottle of saline nasal spray on top of plastic drawers next to his/her TV. Resident #40 was not present in his/her room.<br><br>On 8/13/2025 at 8:06 A.M., Resident #40 was in the dining room waiting for his/her breakfast Resident #40 pointed to a white tablet and told the surveyor that was his/her Lactaid tablet.<br><br>On 8/13/25 at 12:04 P.M., and 8/14/25 at 8:10 A.M., the surveyor observed Resident #40 was not in his/her room and the bottle of Lactase, eye drops, and nasal spray were unsecured in the room. Resident #40's roommate was present and eating his/her meals.<br><br>On 8/14/25 at 8:13 AM., the surveyor observed Resident #40 seated in the dining room, waiting for breakfast, with a Lactaid tablet on the table in front of him/her.<br><br>During an interview on 8/14/25 at 8:59 A.M., Nurse #3 said that Resident #40 keeps his/her medications in a white container in his/her room.<br><br>During an interview on 8/14/25 at 9:34 A.M., the Assistant Director of Nursing (ADON) said that residents should be assessed for self-administration of medications and that medications can be stored in their rooms or in the medication cart. The ADON was not aware that Resident #40's medications were not secured while he/she was not in the room, and his/her roommate was present.<br><br>During an interview on 8/14/2025 at 12:48 P.M., the Director of Nursing (DON) said staff are expected to assess and educate the residents, get a physician order for residents who want to self-administer medications. The DON said medications should be securely stored in Resident rooms when not in use. |

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| F 0778<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Help the resident make transportation arrangements to and from radiology services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Residents were assisted in making transportation arrangements to Radiology appointments for one Resident (#8) out of a total sample of 27 Residents. Specifically, the facility failed to ensure Resident #8 was provided assistance to obtain transportation for a brain Magnetic Resonance Imaging (MRI) appointment as recommended by a Neurologist. Findings include:Review of the facility policy titled Nursing Policy & Procedure Manual Transportation, dated 4/20/2021, indicated the following:- It is the policy of this facility to ensure that residents are transported safely to and from medical/clinical appointments. It is the goal to ensure residents are transferred to their scheduled appointments and/or events.- The facility may opt to obtain contract transportation for the resident.- If a contracted provider cancels scheduled transportation arrangements, parties will be notified as soon as possible. Resident #8 was admitted to the facility in July 2023 with diagnoses including paranoid schizophrenia and epilepsy. Review of Resident #8's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 15 out of 15 indicating intact cognition. Further review of the MDS indicated that Resident #8 requires assistance with activities of daily living and does not have a history of rejecting care. Review of Resident #8's Neurology visit from an outside General Neurology Clinic with a consultation date of 5/12/25 indicated the following:- Reason for the visit: Here for new evaluation and treatment of seizures and sensory impairment.- Patient was previously followed by neurology for multiple issues: Small Seizures- Plan: Imaging: Send for MRI brain for evaluation of parkinsonism Review of a nursing note dated 5/12/25 indicated the following: Resident returned from neurology appointment with n.n.o. (no new orders) at this time, f/u (follow-up) appt (appointment) given. Review of Resident #8's care plan, dated as revised 8/12/24, indicated that the Resident has a diagnosis of Seizure Disorder/history of seizure disorder. During an interview on 8/13/25 at 8:46 A.M., Resident #8 said he/she was waiting to go to his/her appointment a week ago and the facility told him/her it was at 2:00 P.M. and he got a phone call from the transport company that he/she missed his/her ride as it was at 1:30 P.M. Resident #8 said he/she has had seizures and he/she needs to get an MRI. The Resident then said he/she wishes the facility would provide an escort to go with him/her so he/she does not need to worry about things. During a telephone interview on 8/13/25 at 9:16 A.M., Resident #8's family member said he/she has not heard anything from the facility regarding the Resident's appointment. The family member then said Resident #8 has night seizures which started months ago, and he/she has banged his/her head against the wall. The family member then said that he/she only hears from Resident #8 and that he/she has not been to his/her MRI appointment and he/she thinks an escort is necessary for Resident #8. Review of a nurse practitioner progress note dated 2/4/25 at 3:54 P.M., indicated the following: HPI (history of present illness): Patient also had a questionable seizure in May (2024), it was unwitnessed, reported by the patient that when he/she woke up he/she was shaking. Patient was supposed to follow-up with neurology in September however transportation did not arrive. (sic) Review of a nursing progress note dated 6/28/25 at 8:54 P.M. indicated the following: Patient was scheduled for an MRI of the brain today but transportation did not show up. Appointment was rescheduled but pending discussion with U/M (Unit Manager) and U/S (Unit Secretary) as available times are either very early in the morning or very late at night. (sic) Review of a nurse practitioner note dated 6/30/25 at 1:43 P.M., indicated the following: Assessments/Plans: Referral to neurology for questions of seizures, appointment schedule for May 12 (2025), will need follow-up rescheduled. Was scheduled for MRI of the brain, although transportation did not arrive. Will need rescheduling. (sic) Review of a nurse practitioner note dated 7/26/25 at 1:36 P.M., indicated the following: Assessments/Plans: Referral to neurology for questions of seizures, appointment schedule for May 12 (2025), will need follow-up rescheduled. Was scheduled for MRI of the brain, although transportation did not arrive. Will need rescheduling. (sic)<br>(continued on next page) |

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| F 0778<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a nursing progress note dated 8/6/25 at 3:52 P.M. indicated the following: Resident missed appt (appointment) today due to transportation communication. During an interview on 8/13/25 at 11:14 A.M., Unit Manager #2 said if residents have appointments, we (the facility) book the transportation, we then see if a family member wants to join and if not then we bring a staff member as an escort to the appointment. Unit Manager #2 then said she cannot remember if Resident #8 has missed any appointments lately as she is the Unit Manager for two units in the facility. Unit Manager #2 then said Resident #8 should have an escort to his/her appointments as a medical appointment would go over his/her head and it would be too much for him/her. On 8/13/25 at 11:35 A.M., Unit Secretary #1 informed the surveyor of the four transport companies that the facility typically uses to get residents to their appointments. On 8/13/25 at 11:54 A.M., 12:06 P.M., 12:25 P.M. and 12:35 P.M., the surveyor called the four transportation companies, none of which had any record of transportation requests for Resident #8. During an interview on 8/13/25 at 1:14 P.M., Nurse #3 said Resident #8 has had seizures before and he/she is followed by neurology. Nurse #3 said sometimes the Unit Secretary or a CNA (certified Nursing Assistant) will go with him/her. During a telephone interview on 8/13/25 at 2:20 P.M., the Nurse Practitioner said Resident #8 has questionable seizures and is being seen by Neurology, he/she was seen on May 12th and they requested an MRI. The Nurse Practitioner then said he/she was supposed to have one at the end of June and in August, but the resident did not go due to transportation issues. The Nurse Practitioner then said it would be optimal for Resident #8 to receive an MRI of his/her brain right away. During an interview on 8/14/25 at 8:27 A.M., the Assistant Director of Nursing (ADON) said she was unaware that Resident #8 had a history of seizures. The ADON said when a resident comes back from a medical appointment the nurse working will review the discharge paperwork and make note of any follow-ups that are needed. The ADON said transportation has been an issue due to insurance issues. The ADON then said she wishes that all residents could have an escort to their appointments. The ADON and the surveyor proceeded to review the appointment books on the B-Wing Nursing unit. Review of the appointment book at the B-Wing Nursing Station on Resident #8's unit indicated the following on 8/6/25: *Resident #8 @ 2:00 p/u (pick-up) MRI* Review of appointment binder on the B-Wing Nursing Station indicated the following:- A fax form from the MRI clinic for Resident #8 dated 6/27/25 with the title Screening Forms, the following fields were checked off: urgent, for review, please comment, please reply. MRI Appointment date: 6/28/25 6:20 P.M. arrival.- A document dated 7/30/25 in the B-Wing appointment book indicated a new appointment date for 8/6/25 at 2:00 P.M., on the document was a hand-written note indicating that the insurance company was emailed on 7/30/25.- A document titled Doctor's Appointments dated 8/6/25 indicated the following: Reason: MRI, Time: 2:00 P.M. arrival- A document titled Doctor's Appointments dated 9/11/25 for the MRI Center with the hand-written word brain on it. During an interview on 8/14/25 at 8:52 A.M., Unit Secretary #1 was reviewing the appointment books with the surveyor. Unit Secretary #1 said she handles appointments for another unit in the facility, but this floor's Unit Secretary was on vacation. Unit Secretary #1 told the surveyor the facility has issues with getting calls for pick up times on the appointment day, usually the transportation company will call the day of the appointment. Unit Secretary #1 said sometimes we do not know which company will be picking the residents up and sometimes they do not show up. Unit Secretary #1 reviewed the appointment paperwork for Resident #8 and she said the Resident should have been to his/her MRI appointment sooner. At 9:16 A.M., the Unit Secretary #1 called Resident #8's insurance company, the insurance company said transportation came to the facility for the Resident's 8/6/25 appointment but the Resident never came downstairs, so they left. The insurance company said they only had the Resident's phone number and not the facility's phone number. The insurance company then said there was no record of them arranging transportation on 6/28/25. Unit Secretary #1 told the surveyor the insurance company needs the facility's phone number and not Resident #8's so we can make sure he/she makes the appointment. Unit Secretary #1 and the ADON said their expectation is that the facility is responsible for ensuring Resident #8 gets to his/her appointments. During an interview on<br>(continued on next page) |

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| F 0778<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 8/14/25 at 11:48 A.M., the Director of Nursing (DON) said the facility needs to ensure the Resident is ready when an appointment is scheduled. The DON then said appointments need to be scheduled as soon as possible and then rescheduled as soon as possible if needed. The DON said if the facility is having transportation issues then another option needs to be utilized. The DON then said she expects Resident #8 to have his/her appointment made in a timely manner and he/she should have had his/her MRI sooner. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to ensure that an accurate medical record was maintained for one Resident (#52) out of a total sample of 27 residents. Findings include:Resident #52 was admitted to the facility in January 2024 with diagnoses including dementia and repeated falls. Review of Resident #52's most recent Minimum Data Set (MDS) dated [DATE], indicated Resident #52 had a Brief Interview for Mental Status (BIMS) score of one out of a possible 15, which indicated the Resident has severe cognitive impairment. The MDS also indicated Resident #52 had an impairment in range of motion in the left hand and required supervision for eating. On 8/12/25 at 9:10 A.M., Resident #52 was observed lying in bed. His/her morning care had not yet been completed, and his/her left hand was observed lying on the bed without an orthotic on and both feet were lying directly on the bed with no protective boot or pillow. There was no orthotic observed near the bed or in the room. On 8/13/25 at 7:28 A.M., Resident #52 was observed lying in bed. His/her morning care had not yet been completed, and his/her left hand was observed lying on the bed without an orthotic on and both feet were lying directly on the bed with no protective boot or pillow. There was no orthotic observed near the bed or in the room. On 8/14/25 at 6:25 A.M., Resident #52 was observed lying in bed. His/her morning care had not yet been completed, and his/her left hand was observed lying on the bed without an orthotic on and both feet were lying directly on the bed with no protective boot or pillow. There was an orthotic observed near on the bottom shelf of the bedside table. The straps on the orthotic were closed, indicating it had not been used. Review of Resident #52's physician orders indicated the following orders:-Splint to be worn on left hand overnight. Apply with PM (night) care. Remove with AM (morning) care. Check skin each shift, initiated on 3/11/25.-Offload heels every shift as tolerated, initiated on 7/18/25-Left heel bootie apply at hs (night) and remove AM (in morning) check q (every) shift, initiated on 12/20/24.Review of the Treatment Administration Record for August 2025, indicated the nursing staff had marked the above three orders as complete, that Resident #52 was wearing a splint, had his/her heels elevated and was wearing a boot on his/her left heel on 8/12/25, 8/13/25 and 8/14/25. During an interview on 8/14/25 at 6:40 A.M., Resident #52 said he/she is supposed to wear a splint at night and has not been wearing it. The Resident said he/she is agreeable to wearing the splint. The Resident was unable to speak about a boot for his/her left heel. During an interview on 8/14/25 at 6:35 A.M., Nurse #2 said she works the overnight shift and Resident #52 has an order to wear a left-hand splint while sleeping. Nurse #2 said she did not put the splint or the boot on Resident #52 last night and she should not have marked the order as complete if it was not done. During an interview on 8/14/25 at 11:33 A.M., the Director of Nursing said Resident #52 has a left-hand contracture and was provided with a splint from the therapy department for contracture management. The Director of Nursing said Resident #52 also has physician orders for a left heel boot because he/she had a previous pressure injury on the left heel. The Director of Nursing said marking orders as complete when not done would create an inaccurate medical record. During an interview on 8/14/25 at 11:03 A.M., Physician #1 said he would expect orders to be followed as written. |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to accurately code Minimum Data Set (MDS) assessments for two Residents (#38 and #110), out of a total of 27 sampled residents. Findings include: 1. Resident #38 was admitted to the facility in October 2024 with diagnoses including paroxysmal atrial fibrillation and chronic obstructive pulmonary disease. Review of the MDS assessment, dated 7/25/25, indicated Resident #38 is cognitively intact evidenced by a score of 14 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). During an interview on 8/12/25 at 11:18 A.M., Resident #38 was wearing glasses and said he/she is having issues with his/her vision. Resident #38 said he/she goes out to ophthalmology appointments. Review of the physiatry note, dated 7/20/25, indicated: Ophthalmology exam. Patient also evaluated by ophthalmology on 7/1, noted to have reduced VA (visual acuity) of left eye, healthy macula and nerve. Reviewed TIA/ stroke symptoms with patient and to present to ED [emergency Department] if occurs. RTC [return to clinic] in 3-4 weeks for additional testing, scheduled for July 30th, consider neuro optho [ophthalmology] eval. Also noted to have pigmented horseshoe tear of right eye. RTC to [NAME] MEA July 23rd for retina visit. [sic] Review of the MDS', dated 7/25/25, 4/5/25, 1/24/25, and 10/30/24, indicated Resident #38's vision was adequate, and he/she does not wear corrective lenses. During an interview on 8/14/25 at 7:46 AM., the MDS Coordinator said she gathers resident information from the clinical record to complete the MDS assessments. The MDS Coordinator said that the expectation is for MDS' to be coded accurately and that Resident #38 being coded as having adequate vision is not accurate. During an interview on 8/14/25 at 8:42 A.M., the Director of Nursing said that MDS' should be coded accurately. 2. Resident #110 was admitted to the facility in August 2022 with diagnoses including cognitive communication deficit and stroke. Review of the MDS assessment, dated 5/21/25, indicated Resident #110 is cognitively intact evidenced by a score of 14 out of a possible 15 on the BIMS exam. Additional review of the MDS, section B indicated Resident #110's hearing was adequate, and he/she does not wear hearing aids. Review of Resident #110's care plans indicated: Focus: Resident has difficulty understanding r/t [related to] hearing impairment. Interventions: Establish eye contact before communicating. Provide hearing aids as indicated. Speak a little louder, dated 9/14/22. During an interview on 8/13/25 at 9:31 A.M., Resident #110 was in his/her room visiting with his/her roommate. Resident #110 said he/she was wearing his/her hearing aids, but he/she needs a new battery. During an interview on 8/14/25 at 7:46 AM., the MDS Coordinator said she gathers resident information from the clinical record to complete the MDS assessments. The MDS Coordinator said that the expectation is for MDS' to be coded accurately and that Resident #110 being coded as having adequate hearing and not having hearing aids is not accurate. During an interview on 8/14/25 at 8:42 A.M., the Director of Nursing said that MDS' should be coded accurately. |